DOCUMENT RESUME

ED 336 055 HE 024 901

TITLE	Health Professions and Nurse Education. Hearing before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives, One Hundred Second Congress, First Session, on H.R. 2405.
INSTITUTION	Congress of the U.S., Washington, DC. House Committee on Energy and Commerce.
REPORT NO	ISBN-0-16-035404-8
PUB DATE	30 May 91
NOTE	380p.; Serial No. 102-18.
AVAILABLE FROM	U.S. Government Printing Office, Superintendent of Documents, Congressional Sales Office, Washington, DC 20402.
PUB TYPE	Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	MF01/PC16 Plus Postage.
DESCRIPTORS	*Allied Health Occupations Education; Delivery Systems; Educational Change; Educational Trends; Equal Education; *Federal Aid; Federal Legislation; Federal Programs; Futures (of Society); Higher Education; Hospitals; *Labor Force; *Medical Education; *Minority Groups; *Nursing Education; Obstetrics; Postsecondary Education; Rural Areas; Student Loan Programs
IDENTIFIERS	*Public Health Service Act; Reauthorization Legislation

ABSTRACT

The Subcommittee on Health and the Environment met to receive testimony on federal health professions programs authorized by Titles VII and VIII of the Public Health Service Act. These programs are slated for repeal by the Bush Administration in 1992. In particular the subcommittee heard testimony on the subject of critical shortages in training allied health personnel, shortages in clinical personnel for laboratories serving rural hospitals, continuing problems encouraging disadvantaged and minority students to enter health sciences careers, and the need to expand the training of mid-level nurses, nurse practitioners and midwives. The 25 witnesses represented many professional associations and educational institutions including: Deborah M. Bash for the American College of Nurse-Midwives; Marvyn M. Dymally, California Representative to Congress; Leopold G. Selker, American Society of Allied Health Professions; Andrea Morales, a fourth year medical student at the Texas College of Osteopathic Medicine; Robert R. Graham, of the American Academy of Family Physicians; and statements from organizations including the American Academy of Pediatrics; Ambulatory Pediatric Association, American College of Physicians Society of General Internal Medicine and Association of Professors of Medicine. The document also reproduces 26 prepared statements submitted by the various witnesses and organizations. (JB)

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HEALTH PROFESSIONS AND NURSE EDUCATION

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

ON

H.R. 2405

A BILL TO AMEND THE PUBLIC HEALTH SERVICE ACT TO PROVIDE FOR AN INCREASE IN THE NUMBER OF QUALIFIED ALLIED HEALTH PROFESSIONALS SERVING IN TECHNICAL POSITIONS IN CLINICAL LABORATORIES SERVING RURAL AREAS

MAY 30, 1991

Serial No. 102-18

Printed for the use of the Committee on Energy and Commerce

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45-904 WASHINGTON : 1991

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HEALTH PROFESSIONS AND NURSE EDUCATION

THURSDAY, MAY 30, 1991

House of Representatives,
Committee on Energy and Commerce,
Subcommittee on Health and the Environment,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:45 a.m. in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. **Waxman**. Today the subcommittee is meeting to receive testimony on Federal health professions programs authorized by titles VII and VIII of the Public Health Service Act.

Title VII provides support for education in the fields of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, allied health and health administration. Support for students comes in the form of loans, loan guarantees, and scholarships. Institutional support is provided through grants and contracts.

Title VIII authorizes assistance for nursing education through direct assistance to students and institutional support for schools.

These programs embody a wide spectrum of the health care, yet all share a common characteristic: Each has been slated by the administration for repeal. Actually, this is old news. The Bush administration proposal for fiscal year 1992 merely carries on a tradition originating from the Reagan administration.

This tradition has found little favor with Congress. Historically, this committee has repeatedly and firmly expressed its support for continuing Federal funding for education and training of health professions students.

While it is unlikely the administration's current proposal will be endorsed, the reauthorization process does provide an opportunity to consider the direction of these activities and the need for adjustment.

Change is nothing new to these programs. Many owe their origins to congressional initiatives in the 1960's, when their purpose was to increase enrollments at health professional schools and promote the financial viability of these schools. Over time, the focus changed to emphasize education of primary care physicians and advanced nurse education.

The year 1991 marks a new decade where the demands of a budget crisis and the excitement of new opportunities are in constant struggle. It is not unreasonable that we begin this reauthorization process by asking if our existing priorities are properly targeted to the most pressing, most productive health professions needs.

This morning, we will hear about critical shortages in training allied health personnel. We will hear about personnel shortages in clinical laboratories serving in rural hospitals. We will hear about continuing problems encouraging disadvantaged and minority students to enter a health sciences career, particularly in the field of nursing.

We will hear about the need to expand the training of midlevel nurses, nurse practitioners and midwives, to help alleviate critical primary care shortages in underserved communities.

All are legitimate concerns. All warrant our attention and support. And all will require either an increase in current appropriations or a reallocation of existing priorities.

If we are to consider new initiatives, and I hope we will, it should be in the context of their impact on existing programs and on the goal of promoting the most effective investment of what funding is available.

We look forward to the testimony of our witnesses this morning. And let me call on members of the subcommittee for opening statements.

Mr. Richardson.

Mr. **RICHARDSON**. Thank you, Mr. Chairman.

Mr. Chairman, I commend you for holding today's hearing on the reauthorization of title VII and title VIII, the Health Manpower and Nurse Education titles of the Public Health Service Act. These titles authorize critically needed Federal funds to provide health education for primary care practitioners and nursing professionals.

I would like to take this opportunity to offer a special welcome to Allison Kozeliski, a registered nurse from Gallup, N. Mex., which is in my district. I look forward to hearing her suggestions on how we might improve the Nurse Education Act, her insight on how we might begin to provide better access to health care to the underserved, and the impact the nursing shortage is having in New Mexico and nationwide.

Having said that, I would like to reiterate that point: There is a nursing shortage and it is having a negative impact on our ability to provide quality health care and to provide access to care for those most in need, the low-income women, children, and elderly.

Recent reports on the nursing profession by the American Nurses Association and others indicate that one of every eight registered nurse positions in hospitals goes unfilled. The scenario is even worse in nursing homes, where one in every five RN positions goes unfilled.

Moreover, we are now in the fifth year of a "chronic" nursing shortage that began in 1986. The only other nursing shortage of equal duration occurred in the 1950's.

I will shortly be introducing legislation to reauthorize the Nurse Education Act. I will be particularly interested in the testimony today. I would like to welcome Dr. Fitzhugh Mullan with the Public Health Service. He is indirectly a constituent, having served as former Secretary of Health and Human Services in the State of New Mexico.

Mr. Chairman, I am also interested in seeing how the Minority Centers of Excellence have been implemented, legislation we authored last year, with your help, and the primary health care and primary health care system. Thank you.

Mr. Waxman. Mr. Synar.

Mr. Synar. Mr. Chairman, I am pleased to welcome two members of the Rural Health Care Coalition, Congressman Jim Cooper and Congressman Jim Slattery, to testify in front of the subcommittee. I commend both these gentlemen on their leadership and commitment to exposing the inadequacies that exist when it comes to serving the 60 million Americans who live in rural areas.

The legislation they have introduced is extremely important to rural communities, and the focus of the Rural Health Care Coalition. There is a nationwide shortage of rural primary care providers, almost 1,800, and as many as 25 percent of rural physicians are scheduled to retire in the next several years.

H.R. 2231 serves to address this problem by requiring, as a condition for receiving PHS funds, that medical schools have Departments of Family Practice and require clinical experience in family medicine.

I am also concerned about the continued shortage of clinical laboratory personnel in rural areas. H.R. 2405 provides a rational approach to solving these shortage problems. Accessibility to basic, primary care services is absolutely critical to combat health manpower shortages in rural areas.

I look forward, Mr. Chairman, to continuing working with you and the subcommittee members and the Rural Health Care Coalition on these issues and other legislation to benefit rural areas.

Mr. Waxman. Thank you very much.

Our first witnesses are colleagues. Jim Cooper is a member of our Energy and Commerce Committee, and the author of H.R. 2231, a bill to improve primary care training programs. Jim Slattery is also a member of the committee, and author of H.R. 2405, the Rural Clinical Laboratory Personnel Shortage Act. Mervyn Dymally is a Representative for the State of California, and long been interested in these issues.

Congressman Solarz, author of H.R. 2438, will join us this afternoon.

I understand Mr. Cooper, unfortunately, couldn't be with us because he has to chair the session of the House. And without objection, his testimony will be put in the record.

[The prepared statement of Mr. Cooper follows:]

Prepared Statement of Hon. Jim Cooper

Mr. Chairman, thank you for holding this important hearing. I appreciate very much your persistent efforts to find creative solutions to the problems affecting our health care system—both in our rural areas and on a national level.

As Chairman of the House Rural Health Care Coalition's Task Force on Health Professions and Medical Education, I want to remind you of the acute shortages of health professionals in rural areas. I would also like to discuss some ideas I have to use Public Health Service funds even more effectively to reduce shortages of health personnel in both rural and urban areas.

A major health problem in rural areas is the shortage of qualified health personnel. Rural hospitals are closing because they can not find enough registered nurses. Accident victims are twice as likely to die in rural than urban areas because of scarce emergency medical services. And as a result of a decline in training programs and recent regulations, the demand for laboratory technologists and other Allied Health Professionals greatly exceeds the supply. Altogether there are nearly 2,000 medically underserved areas in the country—70 percent rural—with more than 35 million people.

Most critically, there is a shortage of primary care physicians—the backbone of our health delivery system—a shortage which extends beyond rural boundaries and affects the nation as a whole. Most experts agree that we have enough doctors overall, but that we don't have enough primary care doctors. In 1963, 49 percent of doctors were in primary care. By 1986 it was down to 34 percent. And nearly half of our family doctors are older than 55, so a critical shortage will be getting even worse.

The shortage hurts us in two main ways. The first and most obvious way is reduced access to care. When people have to drive 30 miles to see a family doctor, it's little wonder they put off treatment until they are very sick. And that's where we're hurt a second time—in cost. Preventing an illness is much cheaper than treating it. And primary care physicians are the key to providing preventive medicine.

You probably know the U.S. has the highest per capita medical expenditures in the world. But we also have the world's highest ratio of specialists to primary care doctors. That's no coincidence: Primary care medicine is cost-effective medicine, and we need more of it.

Why are there so few primary care physicians? As you might expect, the answer is a combination of disincentives, including longer, more irregular hours, and lower pay than specialists.

We in Congress can't remove all the disincentives, but we have been successful in reducing some of them. For example, we will soon begin to phase in payments under the new Relative Value scale, designed to reduce the gap between primary care physicians and specialists. And, thanks to your leadership, Mr. Chairman, we were able last year to substantially revitalize the National Health Service Corps, which helps remove the disincentive of the tremendous debts these students face.

But there is a further disincentive Congress should help reduce, and that is a disincentive posed by some medical schools—including many of our most prestigious schools—who send a message to their students that the glamour and prestige are in the medical subspecialties and that family medicine is somehow a less desirable career.

While schools like the University of Minnesota, University of California Davis and Michigan State average more than 20 percent of their graduates in family medicine each year, others like Yale, Johns Hopkins and Harvard bring up the rear with an average of 2 to 4 percent of their students in family medicine. In 1989, for example, 1 student from Yale, 3 from Harvard and 3 from Johns Hopkins went into family medicine.

One thing those prestigious schools have in common is that they lack a department of family medicine. Furthermore, they don't even require their students to have clinical experience in family medicine. In fact, of the 20 schools which send the fewest students into family medicine, 14 lack family medicine departments. Of the 50 best, all have departments.

The lack of a family medicine department and lack of required clinical experience are important obstacles, because they make it less likely that students will get the sort of early exposure to family medicine which could positively influence their decisions. Less than 15 percent of medical students know what area of medicine they want to practice at the time they enter medical school, and they, like all students, are influenced by their classroom and clinical experience and by role models at their schools.

How can we get the medical schools to establish departments and place a greater emphasis on family medicine? I suggest that we use Public Health Service funds as a tool. The Primary Care Training legislation I have introduced—H.R. 2231—would require medical schools, as a condition of receiving certain funds under Title VII, to have departments of family medicine and to require clinical experience in family medicine. These funds were originally intended to promote primary care; we need to restore their original purpose.

Harvard, Yale and Johns Hopkins, which educated a total of 7 students in family medicine in 1989, received a combined average of more than $600,000 annually of those scarce Title VII funds in the years 1985–89. Those schools would continue to receive funds only if they are willing to make a greater effort to educate the physicians we most need. Hopefully, this legislation will nudge them in the right direction.

The chief drawback to my proposal may be that it does not go far enough. The $17 million in Public Health Service funds it affects is small change to medical schools with budgets driven by their share of billions from the NIH. But my legislation, which requires no additional money, is certainly a step in the right direction, and should encourage medical schools to do their best to produce the national shortage of family physicians.

Table One.—RANK ORDER OF MEDICAL SCHOOL GRADUATES WHO ENTER FAMILY PRACTICE

Medical school	Average percent	Administrative structure
Wright State	29.1	Department
Southern Illinois	28.3	Department
East Carolina	25.4	Department
Mississippi	24.8	Department
Minnesota	24.6	Department
Arkansas	24.2	Department
Iowa	23.4	Department
California, Davis	23.3	Department
Washington University	22.6	Department
North Dakota	22.4	Department
Michigan State	22.1	Department
South Carolina University	22.0	Department
Kentucky	21.9	Department
Morehouse	21.1	Department
Mercer	20.3	Department
Nebraska	19.7	Department
Virgin Medical College	19.5	Department
Marshall	19.4	Department
South Dakota	19.0	Department
Texas, San Antonio	18.9	Department
California, Irvine	18.8	Department
New Mexico	18.7	Department
Indiana	18.7	Department
Loma Linda	18.6	Department
Texas Tech	18.5	Department
Kansas	18.2	Department
Texas, Houston	18.0	Department
South Carolina, Medical	17.7	Department
Colorado	17.6	Department
Eastern Virginia	17.2	Department
Missouri, Columbia	17.1	Department
East Tennessee	16.5	Department
Jefferson	16.4	Deartment
Mayo	16.4	Department
Oklahoma	16.3	Department
Ohio	15.5	Department
Uniformed Services	15.1	Department
Vermont	14.9	Department
Texas A&M	14.9	Department
California, San Fran.	14.9	Department
Ohio State	14.8	Department
Rush	14.8	Department
Arizona	14.8	Department
Wisconsin	14.6	Department
Nevada	14.6	Department
Texas, Galveston	14.5	Department
South Florida	14.3	Department
Florida	14.3	Department
Louisiana, Shreveport	14.0	Department
California, LA	13.9	Division
Pennsylvania State	13.6	Department
Bowman Gray	13.6	Department
Temple	13.5	Department
South Alabama	13.2	Department
West Virginia	13.1	Department
Virginia	13.1	Department
Creighton	13.0	Department

Table One.—RANK ORDER OF MEDICAL SCHOOL GRADUATES WHO ENTER FAMILY PRACTICE—Continued

Medical school	Average percent	Administrative structure
SUNY, Syracuse	12.8	Department
California, San Diego	12.6	Division
UMDNJ–RWJ	11.9	Department
Wisconsin Medical College	11.8	Department
Pennsylvania Medical College	11.8	(*)
Louisville	11.7	Department
North Carolina	11.6	Department
Wayne State	11.6	Department
Northeastern Ohio	11.5	Department
Cincinnati	11.5	Department
Missouri, Kansas City	11.4	Department
Utah	11.3	Department
Southern California	11.3	Department
Illinois	11.2	Department
Oregon	10.9	Department
Alabama	10.9	Department
Tennessee	10.8	Department
Georgia Medical College	10.8	Department
Maryland	10.7	Department
Meharry	10.6	Department
Massachusetts	10.4	Department
SUNY, Buffalo	10.3	Department
Louisiana, New Orleans	10.2	Department
Howard	10.2	Department
Pittsburgh	9.9	Division
Texas, Southwestern	9.8	Division
Hahnemann	9.6	Division
Chicago Medical	9.6	Department
Loyola	9.5	Section
Baylor	9.2	Department
Dartmouth	9.1	Department
George Washington	8.9	(*)
Michigan	8.1	Department
SUNY, Stony Brook	7.8	Department
St. Louis	7.8	(*)
Georgetown	7.4	Department
Albany	7.3	Department
Rochester	7.2	Department
Hawaii	7.2	Department
Brown	7.0	Department
Duke	6.8	Department
Case Western	6.6	Department
Connecticut	6.5	Department
UMDNJ-New Jersey	6.4	Section
Tufts	6.2	(*)
Miami	5.8	Department
Emory	5.7	(*)
Pennsylvania	5.4	(*)
Boston	5.4	Section
Stanford	5.4	Division
Einstein	5.1	(*)
Vanderbilt	4.6	(*)
Tulane	4.1	(*)
Northwestern	4.0	Section
Washington, St. Louis	3.9	(*)
Harvard	3.9	(*)
Chicago, Pritzker	3.8	(*)
New York Medical	3.3	Department
SUNY, Brooklyn	2.9	Department
Mount Sinai	2.8	(*)

Table One.—RANK ORDER OF MEDICAL SCHOOL GRADUATES WHO ENTER FAMILY PRACTICE—Continued

Medical school	Average percent	Administrative structure
New York University	2.5	(*)
Johns Hopkins	2.3	(*)
Columbia	2.2	(*)
Yale	2.1	(*)
Cornell	1.7	(*)

Notes: Data represent the average percent of graduates from 1980–88 who enter family practice residency programs.

(*) The school has no department, section or division of family medicine.

Mr. Waxman. And I would like to ask Mr. Slattery to come forward, if he would, to give us his testimony.

Before you begin, Mr. Slattery, I want to recognize Mr. Bliley to deliver his opening statement.

Mr. Bliley. Thank you, Mr. Chairman.

I will make my statement brief. I have awaited this hearing for some time because I feel it is necessary that we hear testimony on a topic vital to America's future: Health care education.

We must make sure that moneys are available so that disadvantaged and minority students can go to school and become health care professionals. This is an aim of life; a goal I take very seriously.

Furthermore, nurse education should be a priority of this Congress. In Richmond, the Medical College of Virginia runs an outstanding nursing program. I have seen the great work that they do. It is our duty to ensure that these sorts of programs continue.

So, I await today's testimony. In this critical time, I would love to be able to tell you we will spend *x* on these programs and traineeships, but I just don't know what will be available in this time of fiscal constraint. I expect to move a few steps closer to finding the answer this morning.

Thank you very much, Mr. Chairman.

Mr. Waxman. Thank you, Mr. Bliley. All members will have an opportunity to submit an opening statement for the record.

[The prepared statements of Hon. Stephen J. Solarz and Hon. Terry L. Bruce follow:]

Prepared Statement of Hon. Stephen J. Solarz, a Representative in Congress From the State of New York

Thank you for the invitation to testify before your committee. I believe that your decision to conduct these timely hearings speaks to the importance of health manpower issues. In particular, I would like today to cite the importance of the enormous contributions that international medical graduates [IMGs] have made to the health of all Americans.

Mr. Chairman, I originally introduced the "Fair Physician Reciprocity Standards Act," a bill to prohibit discrimination against international medical graduates, in the 99th Congress. The purpose of this legislation was to prohibit States from discriminating against international medical graduates in granting licensing by endorsement, with the sole exception of the additional years of graduate medical education that a State can require. It was my view then, as it is now, that America cannot afford to discriminate against international medical graduates, who now comprise 22 percent of the nation's practicing physicians, and who serve in some of the country's most impoverished areas.

In fact, "The Fair Physician Reciprocity Standards Act," as well as legislation introduced by my colleagues, has played a significant role in eroding discrimination against IMGs. In particular, there have been three major developments.

First, beginning in 1992, IMGs and U.S. medical graduates will be able, for the first time, to take the same test—the so-called "single pathway" examination—for licensure. Second, the American Medical Association, as well as a number of State Medical Societies, have become increasingly receptive to the concerns of IMGs and have created offices within their organizations to address IMG-related issues.

Finally, Mr. Chairman, as a direct result of your hearings on this critical issue during the 100th Congress, legislation was passed that Mandated the General Accounting Office [GAO] report, "Medical Licensing by Endorsement," released in 1990.

The GAO study clearly documented that most states have different endorsement requirements for graduates of international medical schools and for U.S. medical graduates. The report also highlighted the consensus for a clearinghouse for physician credentials and documentation. Finally, it noted the woeful lack of data on both international and U.S. medical graduates who apply for licensure by endorsement with state medical boards.

In fact, the GAO report cites the case of an IMG who, while licensed to practice medicine in five states, was denied licensure in a sixth state because the state's medical licensing board determined that his medical education was not equivalent to that provided to U.S. medical graduates. The GAO notes that the board arrived at its decision by displacing the burden on the physician to prove the equivalency of his education." The physician found it difficult to address the board's numerous inquiries, such as the credentials of the faculty in his medical school, and whether his school made a practice of issuing fraudulent certificates of graduation.

Furthermore, the report states that several officials of the six state boards visited by the GAO acknowledged that some IMG applications for endorsement required as long as two years to process.

Mr. Chairman, therein lies the rub. The GAO report has uncovered the fact that while some State officials maintain that the process for applying for licensure by endorsement works for international medical graduates, there is little hard data to support this contention. Meanwhile, IMGs continue to face expensive and time-consuming delays and insurmountable obstacles while impoverished communities across the country clamor for additional physicians.

Mr. Chairman, yesterday I introduced the "International Medical Graduate Equity Act of 1991." This legislation is designed to alleviate the most critical aspects of discrimination faced by the international medical community. This revised legislation will include four major elements. First, it bans states from discriminating against IMG physicians who have been licensed and practicing for five years or more and who meet the same criteria in licensure by endorsement as U.S. medical graduates. Second, the IMG Equity Act will mandate Federal funds necessary for the establishment of a national clearinghouse and advisory council to verify and maintain original education documents and credentials for all physicians. This will eliminate time-consuming, costly, and burdensome obstacles that practicing IMGs must now face when state licensing boards require them to verify their educational credentials from schools that are, in some cases, half a world away. In fact, the American Medical Association is currently conducting a pilot program in this area.

Third, my bill will require states to maintain and report data to the Secretary of Health and Human Services on the number of IMGs and U.S. medical graduates who apply for and are denied licenses, as well as the length of time this process takes. This information will aid Congress in tracking and evaluating discrimination against IMGs.

Finally, my bill will bar medical institutions from denying residencies, when there are vacancies not filled by U.S. medical graduates, to qualified IMGs simply because they attended a medical school outside the United States.

In sum, my legislation will provide real remedies for the real discrimination that IMGs currently encounter. I hope, Mr. Chairman, that you will consider this legislation during the reauthorization of the Health Professions Act later this year.

Mr. Chairman, quality and affordable health care is increasingly becoming a priority for all Americans. In our cities, as well as in the more rural areas of our nation, qualified internationally trained physicians are reaching out with their education, expertise, and experience to provide this greatly needed care. At a recent gathering of the international medical community, a beleaguered physician asked, "When will this discrimination ever end?" I hope for the sake of those who could benefit from this care, and for the sake of fairness to these caring and committed doctors, we will be able to answer, "Soon."

PREPARED STATEMENT OF HON. TERRY L. BRUCE

Thank you Mr. Chairman. I ask unanimous consent to submit my full statement for the record.

The reauthorization of title VII and title VIII is needed desperately. In a time of severe budget constraints, many of these important programs are being cut. The population is growing, but health care facilities are facing severe personnel shortages. The new budget rules do not allow any new spending but allow us to shift money around. We must prioritize which fields and programs have the most need and have been the most effective.

In March, I introduced as part of the title VII (seven) program, the "Allied Health Professions Promotion Act of 1991." This field has been severely overlooked. The allied health groups comprise more than 65 percent of the entire health professions field, yet they received a paltry sum of $700,000 in 1989 and $1.4 million in 1990 for special projects.

The shortage of allied health professionals has had a detrimental effect of the quality of the U.S. health care system. Studies and reports from the American Medical Association, the American Hospital Association, the National Institute on Aging and many others, show that the United States faces a diminishing pool of allied health personnel.

Examples of shortages

(1) Shortages of health care personnel include: 16.3 percent for physical therapists, 14.7 percent for occupational therapists, 9.2 percent for speech-language therapists, 9.3 percent for medical technologists and 13.6 percent for cytotechnologists. Currently there are six physical therapy jobs for every one person.

(2) In the past few years, some hospitals have had to close emergency rooms and intensive care beds, cancel elective surgery temporarily and send patients to other hospitals because of personnel shortages.

(3) Forty-eight percent of hospitals nationwide have difficulty recruiting physical therapists, and twenty-five percent of them have problems retaining those they currently employ. The Veterans Administration reported a vacancy rate of 26.3 percent for physical therapists and 19.1 percent for occupational therapists in the V.A. system.

(4) The demand for physical therapists and radiological technologists is projected to rise by 87 percent and 65 percent, respectively, by the year 2000.

The U.S. health care system is being weakened by widespread and sometimes dangerous shortages of skilled health care workers who are needed in hospitals, nursing homes and home care agencies. The proportion of the U.S. population 18 to 23 years old has been declining since the beginning of this decade, and will continue to decline through the mid-1990s.

As a member of the rural health care coalition, I am particularly concerned about the increasing shortages. In my district of 18 counties, 10 are medically underserved and an additional 3 are partially underserved. My bill, H.R. 1466, will begin to address the needs faced in these areas.

As our country's population begins to age and our medicine becomes more sophisticated, the need for physical therapists, occupational therapists and many more health care professionals increases. Congress must not wait for this crisis to become a subject for "60 Minutes" before acting.

Mr. **WAXMAN**. We would like to hear from Mr. Slattery.

STATEMENT OF HON. JIM SLATTERY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Mr. **SLATTERY**. Thank you, Mr. Chairman, and members of the committee.

I appreciate the opportunity to testify here today, and I would first like to commend you, Mr. Chairman, for your sensitivity to these issues that affect rural America and underserved areas of this country.

You have been a true champion and true leader of this area. I appreciate it. I would like to acknowledge I am here today representing the Rural Health Care Coalition, specifically the Hospital Health Care Task Force that I chair.

Representative Richardson, Representatives Synar and Cooper, who are other members of the Energy and Commerce Committee, have been in the past and continue to be outstanding spokesmen. I thank you for your leadership. You all are playing key roles, and I appreciate it.

Today I would like to summarize my testimony and comment just briefly on H.R. 2405, legislation which I and other members of the Rural Health Care Coalition have introduced.

My testimony today will be focused more on the shortage of allied health professionals in rural areas. Let me observe H.R. 2405, as it is currently written, is designed to apply only to rural areas.

I would certainly welcome an amendment to broaden that to apply to all underserved areas in this country, because I know that many inner city areas suffer from the same health care personnel shortages that rural areas suffer from, and in my judgment should be treated the same. I just acknowledge that as I begin my testimony.

Allied health professionals serve an important function and play a critical role in the health care network. Allied health personnel constitute more than 64 percent of the health care workforce, excluding nurses, yet there has been a glaring lack of Federal support for allied health education.

During the period of 1981 to 1989, there were no Federal programs offering such support.

During the last reauthorization of title VII, Congress authorized $6 million for each of 3 years to be shared by over 100 allied health profession groups. But only $737,000 was appropriated for fiscal year 1990 and $1.66 million for the current fiscal year. This $6 million authorization compares to a total authorization of $150 million for title VII programs.

The American Hospital Association, the American Society of Allied Health Professionals, and the Bureau of Health Professions and many other professional organizations have all documented extreme shortages of allied health professionals.

I am concerned that these shortages will adversely affect the ability of hospitals, which oftentimes serve as the central base for health care in rural areas, to provide complete and quality care to their patients.

Specifically, I would like to share my concerns regarding the substantial shortage of clinical laboratory technologists and the need for increased attention and authorization to this area.

Both the American Society for Medical Technology and the American Society for Clinical Pathology have documented nationwide shortages of clinical laboratory personnel. These surveys have documented a medical technologist vacancy rate of 11.6 percent, exceeding the nursing vacancies of 11.3 percent experienced at the height of the nursing shortage.

The shortage in rural areas is even more severe. For example, in my home State, the Kansas Hospital Association has reported vacancy rates of medical technologists of approximately 26.2 percent, twice the national average. This shortage of clinical laboratory personnel threatens access to care in rural hospitals.

Compounding the escalating shortage is an increased need for laboratory personnel. The Bureau of Labor Statistics predicts that an additional 100,000 medical technologists will be needed by the year 2000. These estimates do not take into account personnel requirements under the Clinical Laboratory Improvement Amendments of 1988, which will vastly expand the need for qualified laboratory personnel.

At the same time that demand is growing, schools of medical technology are having difficulty recruiting students. The total number of medical technologist graduates in 1989 was 6,305, representing almost a 50-percent decrease from the number of medical technologists graduated in 1977.

In Kansas, we have witnessed the closure of five medical technology programs between 1978 and 1990. Kansas, which has gone from eight schools offering such programs to three over 12 years, is a typical example of the decline in this area of health education.

The proposed regulations implementing CLIA 88, published on May 21, 1990, are likely to have a significant impact on personnel shortage of rural hospitals. These regulations require virtually every hospital and most physicians' offices to employ medical technologists who either hold 4-year degrees in laboratory technology or demonstrate that they have successfully passed a Department of Health and Human Services proficiency exam. Currently, however, HHS is not authorized to administer a proficiency exam.

A rural hospital which is unable to fully staff its laboratory must send laboratory tests offsite, which increases turnaround time, increases patient stay and drives up health care costs.

With these considerations in mind, Mr. Chairman, I have recently introduced comprehensive legislation to address the shortage of clinical laboratory personnel in rural areas.

H.R. 2405, the Rural Clinical Laboratory Personnel Shortage Act, with bipartisan support from 49 cosponsors, gives Congress the opportunity, under title VII reauthorization, to affirm its commitment to increase the supply of formally educated and certified clinical laboratory personnel. At the same time, this bill provides mechanisms to alleviate immediate and future compliance problems with the implementation of CLIA 88 personnel standards.

H.R. 2405 is designed to reduce both the long-term and immediate shortage of laboratory technologists by:

One, providing $4 million for a loan repayment program for clinical laboratory personnel who agree to serve a minimum of 2 years in a rural area and, I would suggest, any underserved area, and $2 million in grants to schools for outreach programs, MLT/MT articulation programs and interdisciplinary training programs for allied health personnel. It is estimated that these programs could bring an additional 700 students a year into the workforce.

Two, directing the Secretary of HHS to develop within 30 months an accreditation program for personnel certification agencies that would include minimum education, training and experience requirements.

Three, by authorizing the Secretary of HHS to develop, in consultation with relevant organizations, a competency-based exam which measures knowledge and skill, thus providing an alternative route of certification for individuals who do not have a 4-year degree in laboratory technology.

This examination will be administered annually during the 30-month period in which the Secretary is developing the accreditation program for personnel certification agencies.

In conclusion, Mr. Chairman, this legislation is the culmination of extensive meetings and consultations with diverse groups representing laboratory and hospital interests. It outlines a consensus agreement among these groups regarding the most responsible way to ensure an adequate supply of qualified clinical laboratory personnel.

I hope that H.R. 2405 will be given serious consideration by the subcommittee, and request that it be included in the chairman's package when title VII if reported out.

I have attached a copy of H.R. 2405 to my testimony and request that it be made a part of the record. Thank you, Mr. Chairman. I look forward to working with you on this and related health care issues.

[Testimony resumes on p. 23.]

[The text of H.R. 2405 and a letter to Mr. Slattery follow:]

I

102D CONGRESS
1ST SESSION

H. R. 2405

To amend the Public Health Service Act to provide for an increase in the number of qualified allied health professionals serving in technical positions in clinical laboratories serving rural areas, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 20, 1991

Mr. SLATTERY (for himself, Mr. DORGAN of North Dakota, Mr. PENNY, Mr. STENHOLM, Mr. BAKER, Mr. MOLLOHAN, Mr. EVANS, Mr. JOHNSON of South Dakota, Mrs. VUCANOVICH, Mr. POSHARD, Mr. BRUCE, Mr. WILLIAMS, Mr. COMBEST, Mr. ENGLISH, Mr. WILSON, Mr. MCCLOSKEY, Mr. SYNAR, Mr. BOUCHER, Mr. EMERSON, Mr. ROBERTS, Mr. THOMAS of Wyoming, Mr. ORTIZ, Mr. HALL of Texas, Mr. PRICE, Mr. BARTON of Texas, Mr. BEREUTER, Mr. BARRETT, Mr. ALEXANDER, Mr. SKELTON, Mr. HAMMERSCHMIDT, Mr. FALEOMAVAEGA, Mr. NUSSLE, Mr. SMITH of Texas, Mr. MORRISON, Mr. UPTON, Mr. SARPALIUS, Mr. HOLLOWAY, Mr. RAHALL, Mr. CHAPMAN, Mr. LAUGHLIN, Mr. CRAMER, Mr. COSTELLO, and Mr. LIGHTFOOT) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend the Public Health Service Act to provide for an increase in the number of qualified allied health professionals serving in technical positions in clinical laboratories serving rural areas, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Rural Clinical Laboratory Personnel Shortage Act".

SEC. 2. ESTABLISHMENT OF PROGRAMS REGARDING CLINICAL LABORATORIES IN RURAL AREAS.

Part I of title VII of the Public Health Service Act (42 U.S.C. 295j et seq.) is amended by adding at the end the following new section:

"SEC. 799B. INCREASING NUMBER OF QUALIFIED PERSONNEL FOR CLINICAL LABORATORIES SERVING RURAL AREAS.

"(a) LOAN REPAYMENT PROGRAM.—

"(1) IN GENERAL.—The Secretary shall establish a program of entering into contracts with allied health professionals under which, subject to paragraphs (2) and (3), such professionals agree to serve in technical positions as employees of clinical laboratories that principally serve rural areas in consideration of the Federal Government agreeing to pay, for each year of such service, not more than $7,500 of the principal and interest of the educational loans of such professionals.

"(2) SERVICE IN RURAL AREAS WITH SHORTAGES.—The Secretary may not enter into a contract under paragraph (1) with an allied health professional unless the clinical laboratory with which the individual has entered into a contract pursuant to paragraph (3) serves a rural area that has a significant shortage of individuals employed in technical positions with clinical laboratories.

"(3) CONTRACT FOR EMPLOYMENT; MINIMUM PERIOD OF SERVICE.—The Secretary may not enter into a contract under paragraph (1) unless the allied health professional involved—

"(A) has entered into a contract with a clinical laboratory described in such paragraph to serve in a technical position as an employee of the laboratory, and the contract specifies a period of employment with the laboratory of not less than 2 years; and

"(B) agrees not to breach the contract entered into by the professional pursuant to subparagraph (A).

"(4) DEFINITIONS.—For purposes of this subsection:

"(A) The term 'clinical laboratory' means a clinical laboratory that meets the applicable requirement of certification established in section 353(b).

"(B) The term 'technical position', with respect to an employee of a clinical laboratory, means an individual that carries out laboratory examinations or other procedures for purposes of section 353(f)(1)(C).

"(5) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there are authorized to be appropriated $4,000,000 for fiscal year 1992, and such sums as may be necessary for each of the fiscal years 1993 and 1994.

"(b) GRANTS REGARDING EDUCATION AND TRAINING.—

"(1) IN GENERAL.—The Secretary shall make grants and enter into contracts with appropriate public and nonprofit private entities to assist the entities, with respect to the education and training of clinical laboratory personnel, in meeting the costs of projects for—

"(A) the creation of innovative outreach programs that link academic resources with rural clinic settings to provide community based education (such as provide medical technology education courses through telecommunications via satellite);

"(B) additional education and training of medical laboratory technicians, laboratory assistants, and other paraprofessional laboratory personnel with priority given to rapid articulation programs that award baccalaureate degrees in medical technology; and

"(C) the development of interdisciplinary training programs that promote allied health personnel in other disciplines (such as radiology technologists) to become formally educated and certified as clinical laboratory personnel so that they can serve dual functions within an institutional setting.

"(2) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there is authorized to be appropriated $2,000,000 for fiscal year 1992, and such sums as may be necessary for each of the fiscal years 1993 and 1994.".

SEC. 3. ACCREDITATION OF CERTIFYING ORGANIZATIONS.

Section 799B of the Public Health Service Act, as added by section 2 of this Act, is amended by adding at the end the following new subsection.

"(c) ACCREDITATION OF CERTIFYING ORGANIZATIONS.—

"(1) DEVELOPMENT OF PROGRAM.—Not later than 30 months after the date of the enactment of the Rural Clinical Laboratory Personnel Shortage Act, the Secretary shall develop a program for the accreditation of State and nonprofit private entities engaged in the certification of clinical laboratory personnel.

"(2) MINIMUM CERTIFICATION STANDARDS.—In developing the accreditation program required under this subsection, the Secretary shall establish criteria for evaluating State and nonprofit private entities. Such criteria shall be designed to ensure that certificants of accredited certification programs possess adequate education, training, clinical experience, and other measures of proficiency to assure minimally acceptable levels of competence in the fields to which they are certified. Such criteria may include equivalency standards for non-degreed personnel. Individuals certified by an entity accredited under this subsection shall be deemed qualified under regulations promulgated by the Secretary pursuant to section 353(f)(1)(C).

"(3) ANNUAL APPROVAL.—The Secretary shall annually evaluate each entity approved under this subsection to determine if the entity continues to meet the standards established under this subsection and shall withdraw the approval of any entity that no longer meets such standards.

"(4) REPORT TO CONGRESS.—Not less than 90 days prior to formal implementation of the accreditation program required under this subsection, the Secretary shall submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report listing those State and nonprofit private certifying entities whose certification programs appear to qualify for accreditation. The report shall also list any existing certification entities that have been determined not to qualify for accreditation, and the reasons therefor.".

SEC. 4. INTERIM ALTERNATIVE ROUTE OF CERTIFICATION.

Section 799B(c) of the Public Health Service Act, as added by section 3 of this Act, is amended by adding at the end the following new paragraph:

"(5) INTERIM ALTERNATIVE ROUTE OF CERTIFICATION.—

"(A) The Secretary, in consultation with relevant organizations, shall develop and conduct a competency-based examination designed, except as provided in subparagraph (B), to determine the proficiency of individuals who do not meet the formal educational qualifications under section 353(f)(1)(C) for clinical laboratory technologists.

"(B) Subparagraph (A) shall not apply in the case of clinical laboratory technologists performing testing in the areas of cytology, histopathology, histocompatability, or cytogenetics.

"(C) The Secretary shall administer the examination developed under this subsection within 180 days of the date of the enactment of the Rural Clinical Laboratory Personnel Shortage Act, and annually thereafter, until such time as the Secretary establishes accreditation standards under this subsection.".

SEC. 5. EFFECTIVE DATE.

The amendments made by this Act shall take effect October 1, 1991, or upon the date of the enactment of this Act, whichever occurs later.

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American Society for Medical Technology
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(202) 785-3311
(202) 466-2254 (FAX)

The Honorable Jim Slattery
United States House of Representatives
1512 Longworth House Office Bldg
Washington, D.C. 20515-1602

May 16, 1991

Dear Congressman Slattery:

The American Society for Medical Technology (ASMT) is pleased to endorse H.R.2405, The Rural Clinical Laboratory Personnel Shortage Act.

Your leadership on behalf of the Rural Healthcare Coalition has resulted in the introduction of comprehensive legislation to address shortages of clinical laboratory personnel in rural and underserved areas. Rather than presenting a "quick fix" to the problem, this legislation attempts to forge realistic solutions for both the short and long term.

ASMT is particuarly encouraged that the Coalition's bill includes educational funding initiatives for clinical laboratory students and schools to promote service in rural areas. The CAHEA division of Allied Health Education and Accreditation has documented a 25% decline in accredited programs over the past five years, the vast majority of which are hospital based programs. Recent state budget deficits are also beginning to affect university programs, many of whom see their existence threatened as states are forced to cut back educational support.

The proposed regulations under CLIA 88 are likely to have a significant impact on personnel staffing of rural hospital laboratories which rely heavily on military trained veterans and other non-traditional laboratory personnel. While ASMT supports the inclusion in the legislation of a limited time period interim examination to determine the competency of individuals who would not qualify under CLIA 88 standards, we seek assurances from the Coalition that any such examination is developed in conjunction with professional organizations, measures both theoretical and scientific knowledge as well as technical skills, and utilizes recognized methods of validation and grading criteria to safeguard the integrity of the examination process.

We hope that the Coalition will impress upon HCFA the need to move quickly in developing standards for personnel certification agencies and will direct the Department to undertake an expeditious review of all nationally recognized certification agencies. ASMT firmly believes that the certification of laboratory personnel belongs in the private sector and not with the government, and we strongly support the accreditation provisions of this legislation.

ASMT appreciates the thoughtful approach you have taken in introducing this legislation and we applaud your perserverance and integrity, and that of your staff, in attempting to develop a consensus among diverse laboratory and hospital interests. We believe that this legislation outlines an agreement among these groups regarding the most responsible way to ensure an adequate supply of qualified clinical laboratory personnel.

ASMT looks forward to working with the Coalition to ensure passage of this important piece of legislation.

Sincerely yours,

Roma M. Hall

Roma Hall, President
American Society for Medical Technology

cc: The Honorable Charles Stenholm
The Honorable Pat Roberts

Mr. **Waxman**. Thank you very much, Mr. Slattery, for your testimony.

I think the points you raised are very important ones for us to take into consideration. I appreciate the leadership you have given on this issue, time and time again, and it is certainly my desire to work with you to accomplish the objectives you set out.

I know you have other things on your schedule. Let me see if any member has a quick question. Mr. Richardson.

Mr. **Richardson**. Just also would like to join in commending Jim Slattery. Now that he is off the Budget Committee, he can spend more time with us here.

Mr. **Slattery**. I look forward to that.

Mr. **Richardson**. For that reason, Mr. Chairman, his leadership is extremely important, and he has been very generous in tossing bouquets at everybody but himself. He has been a real leader.

Thank you, Mr. Chairman.

Mr. **Waxman**. Thank you, Mr. Richardson.

Mr. Slattery, thank you very much.

Our next witness is Dr. Harmon, Administrator, Health Resources and Services Administration, accompanied by Dr. Fitzhugh Mullan, Director of HRSA's Bureau of Health Professions, and Mr. Michael Heningburg, Director of the Bureau's Division of Student Assistance.

Dr. Harmon—the bells just rang to indicate there is a vote on the House floor. Rather than have you start and interrupt the testimony or questions, we will now run to the floor and vote, come back as quickly as possible, and then we will be pleased to receive your testimony at that point.

We will recess only for as long as it takes to vote and return.

[Brief recess.]

Mr. **Waxman**. Dr. Harmon, we have your prepared statement, and that will be in the record in full. We would like to ask of you, if you would, to limit your oral presentation to us to no more than 5 minutes, so we can have a full opportunity for questions and answers.

STATEMENT OF ROBERT G. HARMON, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, ACCOMPANIED BY MICHAEL HENINGBURG, DIRECTOR, DIVISION OF STUDENT ASSISTANCE, AND FITZHUGH MULLAN, DIRECTOR, BUREAU OF HEALTH PROFESSIONS

Mr. **Harmon**. Thank you, Mr. Chairman, and members of the committee. With me are Dr. Fitzhugh Mullan, Director of our Bureau of Health Professions, and Mr. Michael Heningburg, Director of the Bureau's Division of Student Assistance.

HRSA is responsible for implementing health professions and nurse training authorities under titles VII and VIII, as well as carrying out a variety of other health services and resource programs relating to access, equity and cost of care.

Over the past 25 years, titles VII and VIII authorities have played a major role in helping to assure access to adequate health care services for the people of the United States.

Historically, titles VII and VIII programs have been responsive to new requirements for Federal collaboration with State and local governments, educational institutions, professional organizations, and other interested groups to prepare health professionals to meet changing perceptions of national needs.

While initially the emphasis was on increasing overall supply of personnel, each reauthorization has brought new focus on particular, evolving geographic and specialty shortages.

At this time, the highest priorities of HRSA as an agency are to help assure that all Americans have access to core clinical preventive and primary care health services, to reduce infant mortality through appropriately targeted maternal and child health programs, to expand and improve services to persons with HIV infection, and to promote reform in health professions training programs.

In each of these areas, we must attempt to improve minority health, increase access to health services for families living in poverty, prevent disease and promote health consistent with Healthy People 2000, and reach out to people in rural areas and to other groups having special problems.

An essential component of this strategy is to promote an appropriate supply, geographic distribution, and balance, by discipline, of health professionals. The most recent information available indicates continuing shortages of primary care providers in many areas of the country.

Scarce Federal health professions resources must be targeted toward meeting the needs of the most severely underserved populations.

Within the context of overall departmental priorities and goals, and taking into account existing fiscal constraints, the administration proposes to continue, with modest increases in funding, certain titles VII and VIII programs that have helped most directly to improve the health status of minority and disadvantaged populations; to phase out the HEAL loan program, while targeting available low-cost loan support more specifically toward health professions students from disadvantaged backgrounds; and to provide continued authority for support of training in relation to HIV/AIDS.

I would like to give you a brief update on certain aspects of this. The disadvantaged health profession initiatives are well under way, helping those who need assistance the most. We are seeking to extend the authority of the Health Careers Opportunity Program, which would continue to provide for educational assistance to help individuals from disadvantaged backgrounds to undertake and complete education in the health professions.

We would also hope to continue the Exceptional Financial Need Scholarship Program, EFN, consolidating it with the Financial Assistance for Disadvantaged Health Profession Students [FADHPS] program now being carried out from a setaside of funds from the Health Careers Opportunity Program.

Third, we would seek to reauthorize the Nursing Education Opportunities for Individuals from Disadvantaged Backgrounds Program, which has supported nursing schools and related assistance activities in the nursing profession.

And HEAL and related student loan programs, as I said, we are proposing the phaseout of the HEAL program because it continues to place an unreasonable debt burden on individuals from disadvantaged backgrounds and because, despite considerable effort, we have been unable to reform the program to make it self-supporting.

Given current budget constraints, we believe that the limited Federal dollars available should be targeted for providing low-cost aid to disadvantaged students, including minorities.

To support the training of health professionals for care of persons with HIV/AIDS infection, we propose to continue the title VII authority that has provided for establishment of HRSA's program of AIDS Education and Training Centers, AIDS/ETC's. The 17 currently funded AIDS/ETC's provide for training of primary care health professionals in the prevention, early diagnosis, and treatment of HIV/AIDS, not only in high-incidence metropolitan areas, but also in emerging statistically significant areas, including certain rural areas.

Other important aspects of our approach would be to collaborate with other agencies, like the Health Care Financing Administration. We are having discussions with HCFA regarding graduate medical education financing, and we are considering certain approaches to that for the future.

In conclusion, Mr. Chairman, I and members of my staff look forward to working with you in the coming weeks to develop legislation consistent with the policies of the President's fiscal year 1992 budget for titles VII and VIII.

At this time, I would be pleased to answer any questions you might have.

[Testimony resumes on p. 38.]

[The prepared statement of Mr. Harmon follows:]

STATEMENT

BY

ROBERT G. HARMON, M.D.

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I am Dr. Robert G. Harmon, Administrator of the Health Resources and Services Administration (HRSA) of the Public Health Service. HRSA is responsible for implementing the health professions and nurse training authorities in Titles VII and VIII of the Public Health Service Act, as well as for carrying out a range of other health service and resource programs relating to access, equity, and cost of care. I am accompanied by Dr. Fitzhugh Mullan, Director of HRSA's Bureau of Health Professions, and Mr. Michael Heningburg, Director of the Bureau's Division of Student Assistance.

I am pleased to have the opportunity to appear before you today to discuss the reauthorization of the Title VII and VIII authorities, most of which expire at the end of fiscal year 1991. For more than 25 years, over $8 billion from programs carried out under Title VII and VIII authorities have played a major role in helping to assure access to adequate health services for the people of the Nation. Modified to take account of emerging national priority health needs, the programs should continue to serve this objective in the future.

Historically, Title VII and VIII programs have been responsive to new requirements for Federal collaboration with State and local governments, educational institutions, professional organizations, and other interested groups to prepare health professionals to meet changing perceptions of national needs. While initially the emphasis was on increasing overall supply of personnel, each reauthorization has brought new focus on particular, evolving geographic and specialty shortages.

The Context

At this time, the highest priorities of HRSA as an Agency are to help assure that all Americans have access to core clinical preventive and primary care health services, to reduce infant mortality through appropriately targeted maternal and child health programs and related service activities, to expand and improve services to persons with HIV infection, and to promote reform in health professions training programs to accomplish these other priorities.

In each of these areas, we must attempt, in accordance with Program Directions of the Secretary, to improve minority health, increase access to health services for families living in poverty, prevent disease and promote health consistent with *Healthy People 2000*, and reach out to people in rural areas and to other groups having special problems.

An essential component of a comprehensive strategy is to promote an appropriate supply, geographic distribution, and balance, by discipline, of health professionals. The most recent information available indicates continuing shortages of primary care providers throughout many areas of the country. Scarce Federal health professions resources must be targeted toward meeting the needs of the most severely underserved populations.

Priority Health Professions Needs

Mr. Chairman, you and the members of the Subcommittee are well aware of the continuing disparities in health status of individuals from disadvantaged backgrounds, including racial and ethnic minorities. Your strenuous efforts in support of the enactment by the Congress of the Disadvantaged Minority Health Improvement Act of 1990 are evidence of your recognition of the gaps that remain between the health status of minorities and nonminorities in the United States.

You also are aware that studies have shown that underrepresented minority health professionals are more likely than other health professionals to provide primary care and to practice in underserved areas. In the field of medicine, for example, a significantly larger proportion of minority graduates practice in the primary care specialties. Significantly more minority physicians practice in designated health professional shortage areas and serve more Medicaid recipients.

To bring about a significant increase in the supply of health care providers who will serve the disadvantaged will require intensified efforts to identify potential students and to help them enter and complete health professions training. With respect to provision of appropriate financial assistance to needy health professions students, special issues have arisen as to the continued viability and usefulness of the Federally insured Health Education Assistance Loan (HEAL) programs.

Health personnel trained to diagnose and treat persons with HIV/AIDS infection are also in short supply in the Nation. The June 1988 Report of President Reagan's Commission on AIDS cited a need for training of faculty, basic teaching of professional students, development of clinical training programs in new treatment settings, and continuing education of practicing physicians and other health personnel. To date, HRSA has obligated nearly $60 million for such training.

Within the context of overall Departmental priorities and goals, and taking into account existing fiscal constraints, the Administration proposes:

- to continue--with modest increases in funding--certain Title VII and VIII programs that have helped most directly to improve the health status of minority/disadvantaged populations;
- to phase out the HEAL loan program, while targeting available low-cost loan support more specifically toward health professions students from disadvantaged backgrounds; and
- to provide continued authority for support of training in relation to HIV/AIDS.

Disadvantaged Health Professions Initiatives

The Administration proposes to continue several ongoing Title VII and VIII authorities for programs to recruit disadvantaged students, including minorities, help those students complete their training, and otherwise promote attention to the health needs of individuals from disadvantaged backgrounds. Simply put, we seek to target assistance to those who need it most.

By extending the authority for the Health Careers Opportunity Program (HCOP), we would continue to provide for grants and contracts to health professions schools and other health or educational entities to assist individuals from disadvantaged backgrounds to undertake and complete education in the health professions. The HCOP program supports the recruitment of students and the provision of educational services allowing those students to complete their professional training.

The existing priority in funding for HCOP programs that can demonstrate effectiveness in training of disadvantaged students would be retained. We would add a preference for applicants who, as appropriate, have developed plans and priorities in cooperation with State and local government authorities and will provide a growing share of the funding for proposed initiatives from non-Federal sources.

The main change that we would make to the HCOP authority would be to eliminate the existing set-aside for grants to schools of medicine, osteopathic medicine, and dentistry for scholarships to students who are exceptionally needy and from disadvantaged backgrounds. This set-aside has provided for the funding of a scholarship program that, since 1988, has been very similar to the Exceptional Financial Need Scholarship program discussed later in this testimony. We propose to combine these two scholarship programs.

we would continue the Exceptional Financial Need (EFN) Scholarship program, as noted earlier, combining it with the scholarship program now being carried out under the set-aside of HCOP funds. Available evidence suggests the utility of some form of nonservice-conditional scholarship aid as one means of recruiting disadvantaged students, including minorities. Such aid will help to attract some students otherwise deterred by fear of inability to complete training or by reluctance to incur heavy debts to cover educational costs. In order to compensate for the elimination of the set-aside for scholarships to exceptionally needy and disadvantaged students, we would amend the EFN scholarship program to increase its funding level and to require that the preponderance of EFN scholarships be awarded to students from disadvantaged backgrounds.

we would reauthorize the Nursing Education Opportunities for Individuals from Disadvantaged Backgrounds program, which, as a counterpart to the HCOP program, has supported nursing schools and related entities in recruitment and educational assistance activities in the nursing profession. As in the case of the HCOP program, we would add a preference for applicants that have developed plans and priorities in cooperation with State and local government authorities and will provide a growing share of the funding for proposed initiatives from non-Federal sources.

In implementing the new minority/disadvantaged programs authorized by the Disadvantaged Minority Health Improvement Act, we are considering a revised regulatory definition of "disadvantaged," for purposes of determining if an individual is from a disadvantaged background. Building on the definition currently used in the HCOP and certain related programs, we would include also individuals who come from certain racial/ethnic and economic groups with particular health status and access problems.

HEAL and Related Student Loan Programs

We are proposing the phase-out of the HEAL program because it continues to place an unreasonable debt burden on individuals from disadvantaged backgrounds and because, despite considerable effort, we have been unable to reform the program to make it self-supporting. Given current budget constraints, we believe that the limited Federal dollars available should be targeted for providing low-cost aid to disadvantaged students, including minorities.

Although HEAL loans have represented an important source of "last dollar" support for health professions students who have exhausted other less expensive means of financing their education, such loans have placed particularly heavy debt burdens on minority individuals. For example, among medical students graduating in 1989, 50 percent of minority students had depended at least in part on HEAL loans, compared with 38 percent of all medical students.

The HEAL program has been significantly more difficult and costly to administer than the Federally subsidized Health Professions Student Loan (HPSL) program, in which the greater part of administrative oversight on individual borrowers is provided by participating schools. Although the HEAL program was intended to be self-supporting, claims against the program recently have seriously exceeded income from insurance premiums and other sources. If HEAL were to continue at current levels, between fiscal year 1992 and fiscal year 1996, the average annual appropriation needed to maintain HEAL in accordance with the requirements of the Federal Credit Reform Act of 1990 will be an estimated $60 to $80 million per year.

To meet the demand by disadvantaged students for loans now being met under the HEAL program, we propose additional capital contributions to student loan funds established pursuant to the HPSL program. New loans would be targeted primarily to students from disadvantaged backgrounds. Making increased amounts of low-cost HPSL loans available to these students would help to promote their entry into the health professions and to minimize any "high indebtedness" deterrent to their practicing in underserved areas.

we would emphasize the need for HPSL schools to establish an environment conducive to the completion of professional training by individuals from disadvantaged backgrounds. As a precedent, Schools participating in the new Loans for Disadvantaged Students and Scholarships for Disadvantaged Students programs must have programs for recruitment and retention of disadvantaged students and faculty and meet requirements also for instruction regarding minority health issues, service to the underserved, and mentor programs.

For non-disadvantaged students who have depended on HEAL in the past, we believe aid would continue to be available through several alternative sources. The Administration has proposed that the maximum allowable loan to a graduate student under Department of Education's Supplemental Loans for Students program be increased from $4,000 to $10,000 a year--an amount that would cover the HEAL borrowing of a substantial proportion of health professions students.

Another source of support for certain middle-income students would be the much expanded National Health Service Corps Scholarship and Loan Repayment programs. Finally, several private sector organizations have indicated a strong degree of interest in implementing private programs similar to HEAL. While these private loans would be market-rate loans, they would take the place of market-rate HEAL loans as a "last dollar" form of aid for individuals who had exhausted other resources.

HIV/AIDS Training Authorities

To support the training of health professionals for care of persons with HIV/AIDS infection, we propose to continue the Title VII authority that has provided for establishment of HRSA's program of AIDS Education and Training Centers (AIDS/ETCs). The seventeen currently funded AIDS/ETCs provide for training of primary care health professionals in the prevention, early diagnosis, and treatment of HIV/AIDS not only in high-incidence Metropolitan Areas but also in emerging statistically significant areas including certain rural areas.

With the passage of the Ryan White Act, it is anticipated that there will be an increased demand for clinical training of primary care providers particularly in those cities which have bean identified as major epicenters of infection. Consistent with the findings and recommendations of the 1990 Report of the National Commission on AIDS and a fiscal year 1990 Evaluative Study (John Snow, Inc.), among other studies, current project requirements are designed to direct Federal resources where the greatest needs exist.

Our purpose is to continue to develop an educational intervention that will provide a sustained, multidisciplinary source of personnel relating to the primary health care needs of high risk and infected HIV/AIDS individuals. Emphasis will continue to be placed on the development of appropriate clinical training experiences. It has been shown that health care providers overcome barriers to treating AIDS patients if they can be prepared in an educational environment where their concerns can be addressed and their skills practiced.

The AIDS/ETCs program was originally funded under the general authority of section 301 of the PHS Act. In 1988, specific Title VII legislation was enacted (section 788A) which limited eligibility to schools and academic health science centers and provided for support of certain types of AIDS training only. The current AIDS/ETCs are supported under both section 788A and section 301. Other approaches to continue this support are under consideration.

Collaboration with Other Agencies

As we look ahead at ways to assure a supply of primary care providers and other health personnel to provide health care to underserved populations, it is clear that we must collaborate with other Federal agencies as well as with a range of non-Federal entities in addressing needs. Such collaborative approaches are needed not only to allow us to draw on the maximum variety of funding resources but also to provide for the development of training programs that are responsive to national and community health problems and priorities.

With respect to the training of primary care providers, including non-physician as well as physician providers, we are particularly interested in further examining the linkages between our programs and those of the Health Care Financing Administration (HCFA) in the nurturing of primary care training and practice. HCFA recently sponsored an invitational conference to address the issue of Medicare financing of graduate medical education. Included in the discussions were options for encouraging primary care education and service.

Also, the Public Health Service and the Health Care Financing Administration plan to convene next year a major national conference on primary health care with the objective of strengthening the role primary care plays in the delivery of health care to all Americans. This conference will examine primary care from the varied but interrelated perspectives of health professions education, financing, services delivery, and research. Among the issues that will be addressed will be questions relating to the content and financing of education in primary care.

In the field of nursing, the Commission on the National Nursing Shortage, which was established to assist in implementing the recommendations of the 1988 Secretary's Commission on Nursing, recently held its final meeting and will be reporting to the Secretary soon on its recommendations to address remaining nurse shortage problems. The Commission was charged specifically with promoting and identifying specific commitments from private sector organizations and the range of governmental authorities for support of proposed projects.

Conclusion

Mr. Chairman, I and members of my staff look forward to working with you in the coming weeks to develop legislation consistent with the policies in the President's fiscal year 1992 budget for Titles VII and VIII. At this time, I would be pleased to try to answer any questions you may wish to ask.

Mr. WAXMAN. Thank you very much.

The administration has proposed, again, to terminate support for virtually all title VII and title VIII health manpower programs. Total funding was reduced by $183 million. The only programs funded by the President's 1992 budget were those providing Federal support for disadvantaged and minority health professions education. Nursing is particularly hard hit with a cut from $60 million to $4.1 million.

Maybe you could answer a few questions on this point. Is it your view that the nursing crisis is over?

Mr. HARMON. We have seen a steady increase in the overall supply of nurses in the United States. Unfortunately, the demand has increased even faster. It is the administration's position to seek to support disadvantaged nursing assistance and to also support such specialists as nurse practitioners and certified nurse midwives, through service-related scholarships and other means under the National Health Service Corps program.

Mr. WAXMAN. Let me ask the same question with regard to the need for Federal assistance to promote the education of nurse practitioners and nurse midwives.

How do you justify eliminating similar support for nurse anesthetists when the hearing we had earlier in the year on the Persian Gulf War demonstrated that shortages of nurse anesthetists often had more to do with curtailing rural hospital services than shortages of doctors?

Mr. HARMON. Again, these are tough decisions. We have sought to target our resources in the primary care area and service-related scholarships. We have other rural health programs under way, such as rural health outreach grants, which can be used to help recruit and retain personnel such as nurse anesthetists in needy rural areas.

Mr. WAXMAN. In the HEAL program, there are variations in default rates by individual health professions schools or within professions. For example, are default rates for medicine or osteopathy different than for chiropractic or dentistry?

Mr. HARMON. I would like to turn to my colleagues here. Perhaps Mike Heningburg, who is our program manager, would seek to address that one.

Mr. HENINGBURG. Mr. Chairman, in terms of the major professions participating in HEAL, chiropractic, dentistry, and podiatry have the highest default rates, in the vicinity of 13 percent. Allopathic and osteopathic medicine are in the vicinity of 5 to 5.5 percent.

Mr. WAXMAN. The rates of default are specifically higher among chiropractic school than any other health school. You said efforts have been made to make the program self-supporting. Have you considered proposals to disqualify particular schools from participating in HEAL whose default rates are high.

You have also indicated to us that inadequate income at the time of repayment is the major reason for default. Have you considered efforts to increase the length of time HEAL loans can be deferred?

Mr. HENINGBURG. We are developing a performance standard which would speak to those participants in the HEAL program with unusually high default rates, and terminate their future participation in the program.

In terms of deferrals, there are several provisions in the existing regulations for forbearance and graduated repayment in case of need.

Mr. **Mullan**. If I might, Mr. Chairman, while we are not by any means insensitive to the financial burden of getting through health profession schools, the HEAL instrument has been felt to be one that is very burdensome in the long run to the student and to society.

It will cost us roughly $50 to $60 million this year to keep the program solvent, and each succeeding year, and that is in the order of magnitude of the funding of the entire National Health Service Corps. We are talking about a very substantial cost to society for the bad debt of the program, and we think there are ways that we can continue to support students and use those dollars in better ways.

Mr. **Waxman**. During the last reauthorization of the nursing program, a provision was added requiring that an independent evaluation be conducted on the extent to which each of the nursing programs have met the legislative objectives. The conclusion of the report, expressed to the committee in a letter from Secretary Louis Sullivan, is that:

> Federal nursing support is seen as an important source of development and start-up funds in graduate nurse education, and that it serves as an incentive and catalyst for innovation in nursing practice.

My question is twofold: One, are similar independent evaluations conducted on the title VII programs? If not, should a similar evaluation be required for title VII programs, and, two, are the Secretary's flattering characterizations of Federal support for nursing programs consistent with the President's 1992 budget recommendation that these programs be largely discontinued?

Mr. **Mullan**. In the matter of the evaluation of title VII programs, there are specific evaluations being carried out relating to title VII programs, which are broader in scope and in numbers of disciplines involved than the nursing programs.

Evaluations have been conducted in such areas as family medicine training, area health education centers, and the like.

It would be our position that an omnibus title VII evaluation requirement probably would not be useful. We would be happy to submit for the record the various evaluations that have been conducted of parts of title VII in the last several years.

I would say in general, we are fairly vigilant about evaluating those programs. As to the question of the evaluation of title VIII programs and the President's budget, certainly the value in the past of the title VIII programs is indisputable.

The question as to the future funding of those programs, I believe, has been addressed by Dr. Harmon.

Mr. **Waxman**. Thank you very much.

Mr. Towns?

Mr. **Towns**. Thank you very much, Mr. Chairman.

Why has the emphasis for Federal support been on graduate education in nursing, rather than in career ladder type of approaches?

Mr. **Harmon**. Dr. Mullan, take that.

Mr. **Mullan**. That, Mr. Towns, is an important question, one that I asked when I first was privileged to superintend these programs. The feeling of the nursing community has been that one of the very significant impediments to expanding the population of practicing nurses, the bottlenecks as it were, is in education of sufficient faculty to train the number of nurses that we need in this country, so that the dollars spent—as you correctly observed, they are for the most part under title VIII, dedicated to graduate training—are seen as an effort to continue to increase the size of the faculty pool within schools of nursing, and thereby combat the impediment of insufficient faculty to educate adequate numbers of nurses.

That is, I believe, the philosophy.

Mr. **Towns**. What is the rationale for requiring undergrad nursing scholarships to have a 2-year service payback for each year of Federal support? It is my understanding that other programs only require a year-for-year payback. Isn't this an unfair financial burden for nursing students?

Mr. **Heningburg**. Mr. Towns, the law requires a year-for-year payback but a minimum of 2 years of service. The requirement has not proven to be unacceptable to the students. We are always oversubscribed to participate in the program. Most students who graduate and are licensed do in fact practice. The list of places where scholarship recipients may practice encompasses practically every health care institution in this country, to include hospitals, to include military, to include community health centers.

Mr. **Towns**. The fairness didn't bother you?

Mr. **Heningburg**. The fairness did not bother us, and we did not receive any comment from the public about that issue.

Mr. **Harmon**. I could comment. Although there is a year-for-year service requirement for a National Health Service Corps scholarship, there is still a minimum of 2 years of payback required. If there are 2 years of scholarship aid, it is still 2 years of service.

Mr. **Towns**. Let me ask this, and my final question, Mr. Chairman. Does the administration have a strategy to enhance greater student interest in the primary care specialties?

Mr. **Harmon**. Yes, we do, and Dr. Mullan could comment on that.

Mr. **Mullan**. It is generally felt that we are deficient, broadly speaking, in this country in terms of our primary care physicians, nurses and other health care providers. That we perhaps are too specialty-oriented, and unfortunately, growing more specialty-oriented as you look at the figures of recent graduates of medical school and other health profession schools.

We have begun to talk actively within the last 6 months within the administration about how programs within the administration, within the Bureau of Health Professions, in particular, and HRSA, can be managed in a fashion that will be more effective in promoting primary care education and continued practice in primary care after training, as well as efforts to collaborate with others, including some very significant foundation efforts.

The Pew Foundation is very interested, and we have talked with our colleagues in the various professional organizations such as the

American Academy of Family Practice. We have worked with various nursing organizations. We are attempting to craft a strategy that would put a great deal more focus on the primacy of primary care, building a firm foundation for our health system for primary care, to try to reverse the erosion in primary care that has taken place in recent years.

Mr. **Harmon**. The centerpiece of the administration's primary care effort would be National Health Service Corps scholarship and loan repayment programs, which strictly require primary care practice in health professional shortage areas, where you know what you are getting and you get service in return for scholarship aid; plus community and migrant health service programs.

Mr. **Towns**. Thank you very much.

I have no further questions, Mr. Chairman.

Mr. **Waxman**. Thank you, Mr. Towns.

Mr. Kostmayer?

Mr. **Kostmayer**. Thank you very much, Mr. Chairman.

I wanted to ask, I guess you, Dr. Harmon, about some of the cuts in the programs which helped to fund the medical education, and I guess you probably spoke about those in your testimony. I am sorry I wasn't here.

Programs like the HEAL program, you are eliminating that, is that right?

Mr. **Harmon**. Right. We are proposing that, and as an alternative, we would propose to expand the Health Profession Student Loan Program as a better approach, better use of scarce Federal resources.

Mr. Heningburg might want to elaborate.

Mr. **Kostmayer**. Targeted towards minorities?

Mr. **Harmon**. Disadvantaged, including minorities.

Mr. **Kostmayer**. How about good old-fashioned middle-class people?

Mr. **Harmon**. We have some proposals in that area, as well, that there are other alternatives.

Mr. **Kostmayer**. Such as?

Mr. **Harmon**. National Health Service Corps scholarships in return for service, for one.

Mr. **Kostmayer**. That program you just mentioned is being held at existing levels?

Mr. **Harmon**. The Corps is expanding dramatically, as a matter of fact, with the administration's proposals. The scholarship went from 10 million to 50 million in the past to the current fiscal year, and——

Mr. **Kostmayer**. The proposal for next year?

Mr. **Harmon**. A $5 million increase. The field budget for paying salaries for NHSC people has also gone up accordingly.

Mr. **Kostmayer**. Let me ask you about the increase for next year, that brings it up to the 1980 level?

Mr. **Harmon**. It will not be up to peak level.

Mr. **Kostmayer**. It won't be up to the 1980 level, and we have had inflation in the country since 1980; is that right?

Mr. **Harmon**. True. But again, we are seeking to approach those previous levels.

Mr. **Kostmayer**. You are not making it. So what we are talking about is programs to send young people in this country to medical school, which are now below the levels at which they were in 1980, and that is not taking into account inflation.

Do you think it is really fair to characterize the administration's approach as increasing these programs, Doctor?

Mr. **Harmon**. They are certainly on the increase.

Mr. **Kostmayer**. On the increase, compared to what? Don't you think it is more honest to say the programs have been pretty dramatically cut over the last decade, and you are now making an effort to get them up to where they were in the 1980's?

Mr. **Harmon**. That is true. There were major cutbacks in the eighties, but we are trying to rebuild those programs and do other things as well.

Mr. **Kostmayer**. Let me give you a hypothetical example.

Mr. and Mrs. Smith have a daughter and they want to send her to medical school, and Mr. Smith drives a cab in Philadelphia, Pa., and Mrs. Smith is a school teacher.

He makes about $20,000. She makes about $25,000. They make a total of $45,000 a year.

Take-home is $30,000.

They have three children.

The first year of medical school at the University of Pennsylvania will cost $18,200, I am told, with $8,000 for living costs, books, cleaning and food and housing; $8,000 a year.

That comes to $26,000 a year.

According to your people, they can get 7,500 bucks from GSL and $3,000 from the Perkins loan.

That comes to $10,500.

They don't qualify for HPSL and you are going to eliminate HEAL.

So young Miss Smith is short $15,500.

Mr. **Harmon**. This person could apply for a National Health Service Corps scholarship.

Mr. **Kostmayer**. How much could she get there?

Mr. **Mullan**. Full tuition and a stipend for living.

Mr. **Harmon**. Another alternative would be a less expensive——

Mr. **Kostmayer**. To qualify for that program, she would have to commit herself to practicing in a given area.

Mr. **Harmon**. Correct.

Another alternative would be a less expensive State-supported medical school, and then there are private sector loans also available.

Mike might want to comment on those alternatives.

Mr. **Kostmayer**. We know that the private sector hasn't done everything they are supposed to.

We were told in 1981 that the private sector would make up for the loss, that if poor people needed care, they could show up at the doctor's back door and that churches would fill in.

Of course, that turned out to be totally untrue.

It turned out that people with more money contributed less than people with less money.

Mr. **Harmon**. It is true that the problem of uninsured care has not been headed in the right direction.

We are supporting an expansion of community and migrant health centers in shortage areas, in inner city and rural areas, in an attempt to address that as well.

Mr. Kostmayer. But you are cutting those programs from the inner cities, 40 percent of the people that some of the university funded programs, for example in Philadelphia, Temple University of Pennsylvania, where they have set up clinics in poor neighborhoods, those programs are being cut.

People have told me they may have to close several of their community clinics if those cuts go through.

Mr. Harmon. Are you referring to support for primary care?

Mr. Kostmayer. Primary care, residential programs, family medical, internal medicine, pediatrics, all those programs which serve the great universities in America's large cities, 40 percent of people they serve are poor and if those programs are cut and universities get less, they will have to close these programs or reduce them.

Mr. Harmon. Those are tough decisions.

Mr. Kostmayer. What is tough about that?

That is the easiest decision in the world.

I have no problem with that decision at all, nothing easier.

Mr. Harmon. We are looking at other sources of funding for some of the programs.

The biggest funder of graduate medical education is the Medicare program.

A total of $4.7 billion goes into indirect and direct costs of graduate medical education and other costs of health professions training; and we are discussing how those funds could be used to enhance primary care in shortage areas.

We are looking for new approaches there and may have some proposals in the future.

Mr. Kostmayer. My time is about to expire.

I am not picking on you. I am sure privately you agree with me more than you agree with the people you work for, but we are talking about making it much more difficult for middle-class people to go to medical school.

The Bush administration's programs will make it much more difficult for middle-class students to enter medical school in the United States and the Bush administration programs attack the very weakest and poorest people in our society, especially poor minority children in our great cities.

It is a disgraceful program, in my opinion.

Mr. Harmon. Our programs here are targeted on disadvantaged and minority students and other service programs, such as Healthy Start, are targeted on the highest risk communities, so we are trying to focus on the most needy.

Mr. Kostmayer. Thank you.

Mr. Waxman. You are trying to focus on disadvantaged students under titles VII and VIII.

Could you give us the administration's technical and working definition of disadvantaged, including any income standards used?

What percentage of the current health profession students fit that definition?

Mr. Harmon. Mike might want to comment.

I could say that the definition is undergoing revision based on recent legislation.

Meanwhile, we are using the existing definition.

Mr. Waxman. Are you redefining disadvantaged out of existence?

Mr. Harmon. No.

Mr. Waxman. Then what is the existing definition that you are using?

Mr. Harmon. This would be an individual who comes from an environment that has inhibited the individual from obtaining the knowledge, skill and abilities required to enroll in or graduate from a health professional school or program or comes from a family with an annual income below a level based on Federal standards.

Mr. Heningburg. That is essentially the definition that we are now using.

We use that in the Financial Assistance to Disadvantaged Health Professions Student program and propose to use that definition, at least initially, in the minority disadvantaged health programs.

Mr. Waxman. What is a disadvantage, an economic disadvantage?

Mr. Heningburg. There may be an economic disadvantage in terms of the family income or a cultural disadvantage in terms of the individual's educational background—the individual's testing on national examinations and the way the institution views the individual.

Mr. Waxman. Mr. Kostmayer gave an example of a young woman who may want to go to medical school. Her father is a taxi cab driver. Her mother is a teacher.

He gave figures as to income.

Would that young woman be considered disadvantaged?

Mr. Heningburg. You mentioned a mother and father with two children. They would probably not qualify as being disadvantaged.

If I may, I would like to——

Mr. Waxman. If that family were Hispanic, would that make a difference in whether they are disadvantaged?

Mr. Heningburg. There may be an economic disadvantage in terms of the family income or a cultural disadvantage in terms of the individual's educational background—the individuals testing on national examinations and the way the institution views the individual.

Mr. Waxman. Mr. Kostmayer gave an example of a young woman who may want to go to medical school. Her father is a taxi cab driver. Her mother is a teacher.

He gave figures as to income.

Would that young woman be considered disadvantaged?

Mr. Heningburg. If the family were Hispanic, if the daughter scored less than the national average on the aptitude test or had a grade point average below that the University of Pennsylvania normally would be looking for, yes, that individual would be disadvantaged.

On the cultural disadvantaged end of it——

Mr. Waxman. If she were Hispanic, but didn't have a low score and the income were the same, would she be considered disadvantaged?

Mr. Heningburg. We would leave that determination up to the school, and they again would use the criteria that we have been talking about.

The school may decide that the individual is disadvantaged.

They may decide that the individual is not.

Mr. Kostmayer. If her mother were Hispanic, but her father Polish——

Mr. Waxman. If her parents were Polish or from an Eastern European country and didn't fit into the disadvantaged categories that this administration talks so much about, traditional ones, and their economic situation was tough, she would be out of luck.

Does the fact that she is a woman make a difference?

Mr. Harmon. That is not one of the criteria.

Mr. Waxman. What if it were a real low-income family, not in any of the racial ethnic categories, but their income is fairly low.

Mr. Heningburg. That individual under the current definition would qualify as disadvantaged.

Mr. Waxman. How low do they have to be?

Mr. Heningburg. We use the Bureau of Labor Statistics guidelines geared to the size and income of the family.

We could provide the figure for the record.

Mr. Waxman. If they qualify, what does the individual get?

Mr. Heningburg. If they qualify, the school develops a financial aid package for that individual taking into account the Department of Education program and the various programs administered by the Bureau of Health Professions. This year we are awarding $6 million for the FADHPS program and $10 million for the EFN program; and 60 HPSL schools have $65 million in their revolving health professions student loan funds.

Mr. Waxman. You indicated you're working on changing this definition.

What are you looking to do to change this definition?

Mr. Heningburg. The report language accompanying the Disadvantaged Minority Health Improvement Act of 1990 encouraged us to broaden the definition so that it is more inclusive and not so much dependent on an individual's income status.

There will be a notice published for public comment.

Mr. Waxman. If you are of a certain ethnic racial category, you could be wealthier?

Mr. Heningburg. I would rather not comment on that since the definition is not cleared through the Department.

Mr. Waxman. You are changing the definition to make it oriented toward ethnic and racial disadvantaged as opposed to economic disadvantaged?

Mr. Heningburg. That is a major emphasis in the new definition.

Mr. Waxman. This is at a time when you are recommending that the HEAL loans, which would go to anybody be reduced from $260 million to $60 million?

Mr. Heningburg. If I might add something on our proposal to terminate the HEAL program, the administration has proposed that the funding for the SLS program be increased from $4,000 to $10,000 a year.

In addition, we have identified at least three private organizations that are willing to pick up a good part of the HEAL portfolio at this point and it would be our intention that the middle-income students that Mr. Kostmayer was talking about would continue to have access to programs, but they would be run by the private sector rather than guaranteed by the Federal Government.

Mr. **Waxman**. What programs are run by the private sector?

Are you talking about going to a bank and getting a loan?

Mr. **Heningburg**. No, there are several organizations that run guaranteed loan programs.

We have identified at least three that are interested in pursuing this.

Mr. **Waxman**. We would like to have the three that are available and how much money would be available and their criteria for lending money.

[The following information was received for the record:]

The following private firms have expressed interest in providing market rate loans to health professions students in the absence of HEAL: HEMAR Insurance Corporation, Sioux Fall, S. Dak.; University Support Services, Herndon, Va.; and The Education Resource Institute [TERI], Boston, Mass. The firms have not presented the detailed information requested by the chairman. University Support Services has expressed an interest in meeting with committee members or staff to further discuss their interest in providing loans to health professions students.

Mr. **Kostmayer**. The SLS program you are increasing from $4,000 to $10,000?

Mr. **Heningburg**. That is part of the administration's proposals; yes.

Mr. **Waxman**. That is the amount that an individual student could borrow?

Mr. **Heningburg**. Yes.

Mr. **Waxman**. But you are not increasing the amount of money you want to spend on the program?

Mr. **Heningburg**. The current maximum limit for the SLS program is $4,000 a year.

The administration is proposing to increase that to $10,000 a year.

Mr. **Kostmayer**. Within the framework, fewer people will qualify for money.

Mr. **Heningburg**. SLS is a guaranteed loan program.

Mr. **Kostmayer**. You are not increasing the pie.

Mr. **Mullan**. It is a guaranteed program in which the loan comes from a third party.

The Government role is to guaran [illegible] $10,000 as opposed to the previous $4,000.

Mr. **Kostmayer**. Would they guarantee more overall?

Mr. **Heningburg**. We understand that, yes, they would.

Mr. **Mullan**. That is—the HEAL program is a guaranteed loan program, so the loans——

Mr. **Kostmayer**. That is the one you are going to eliminate?

Mr. **Mullan**. Yes.

Mr. **Kostmayer**. That serves 38 percent of Americans going to medical school; is that right?

Mr. Heningburg. Of medical students graduating in 1989, 38 percent had relied in part on HEAL loans to finance their 4 years of education. Medical student HEAL borrowers in fiscal year 1990 represented 19 percent of all medical students enrolled in that year.

Mr. Mullan. The current situation with the loan is that the funds are guaranteed by the Government.

The other participants outside of the students which are banks and intermediate institutions as well as schools do not risk-share in any fashion. So the $57 million requested in this year's budget to make up for past bad HEAL loans is an amount of the order of magnitude that will continue to be required each year for years to come if the HEAL program continues—representing a savings and loan kind of situation for the Federal Government. We are not unsympathetic to the needs of students by any means.

We are asking with this proposal——

Mr. Kostmayer. They don't want your sympathy. They want your money.

Mr. Mullan. We are asking with this proposal that we examine the ways in which the Government administers this effort to assist students. Our arguments for phasing out HEAL are that there are better ways to provide student aid. It is not an all-or-nothing phenomenon.

There are many ways that this program could be fixed. We have proposed those in legislative amendments as well as in regulatory form.

Mr. Kostmayer. None of these programs can be fixed by these dramatic cuts.

Mr. Mullan. We argue and I think with fair credibility given the material Mr. Heningburg gave you, that there are other guarantors in the marketplace who will step in and in a fashion very similar, with more discipline, manage these programs which are costing more than the total cost of the National Health Service Corps every year to bail them out.

That represents a substantial leakage of dollars that otherwise could go to support programs or students——

Mr. Kostmayer. Let me go back to Mr. and Mrs. Smith.

They own a house. That is an asset.

Mrs. Smith, a teacher, has a modest pension fund.

Do those assets count against them in their daughter's ability to borrow from these programs?

Do they reduce the likelihood that she can borrow?

Mr. Heningburg. I believe that the family would be encouraged to use those assets.

Mr. Kostmayer. How are they going to use their house?

Mr. Heningburg. You mentioned a pension fund that they draw some money from.

Mr. Kostmayer. They are not retired.

Mr. Heningburg. I would like to respond for the record.

There is a complicated analysis system——

Mr. Kostmayer. Give me a general answer.

Does it count against them that they are homeowners and have a pension fund?

Mr. Heningburg. Not necessarily.

I would like to clarify that answer in the record.

[The information follows:]

To determine financial need for the HEAL program, HHS uses the congressionally mandated need analysis system that was established for Department of Education programs as part of the Higher Education Act. Under this system, home equity and pension funds of a student's parents are evaluated as potential resources for dependent students, but are not evaluated for independent students. (It should be noted that the majority of graduate students qualify as independent, in accordance with criteria set forth in the Higher Education Act.) Where parents' assets are considered, there is an allowance which protects a certain amount of the pension funds based on the ages of the parents. In addition, financial aid administrators are authorized by law to use their professional judgment to make adjustments to any part of the need analysis computation to more accurately reflect the student's actual financial situation.

Mr. **Kostmayer**. My conclusion, which may not be correct, is the opposite, that it does count against them.

In general, do you think this program goes in the right direction or the wrong direction?

Do you think it is good that they are going to have such a difficult time sending their child to medical school?

Mr. **Harmon**. I previously mentioned some other options they may have in this regard and I wish we had the resources to assist families like this, but with tight resources, we have to put them where the need is greatest, with the disadvantaged, minority populations, and service-related programs.

Mr. **Kostmayer**. We have the resources, Doctor.

We are just spending them wrong.

Thank you.

Mr. **Waxman**. Is the need greater for the family that has fewer economic opportunities available to them?

In other words, a poorer family economically, or is the need greater with a family that is wealthier in comparison, but fits into certain racial ethnic categories?

Mr. **Heningburg**. The need is greater with the poorer family in the scenario you described.

Mr. **Waxman**. You are changing your definition of disadvantaged to move away from that kind of balance you said.

Mr. **Heningburg**. We are directed by law to make sure that the funds which we administer go to families with the greatest economic need.

Mr. **Waxman**. Say that again.

Mr. **Heningburg**. We are directed by law and by the regulations that govern these programs to make sure that the available funds go to the families with the greatest need.

Mr. **Waxman**. The greatest need is an economic need?

Mr. **Harmon**. I believe we are also directed, in connection with the enactment of the new disadvantaged minority health law, to redo the definition as well.

In addition to the family's needs and the students' needs, we have to look at the general population's need. Minority populations, with all their disparities in health status and gaps in access to care, need more minority health practitioners.

We think that is justified.

Mr. **Waxman**. Mr. Richardson, did you want to ask questions?

Mr. **Richardson**. Yes.

Mr. Waxman. You are recognized for that purpose.

Mr. Richardson. Dr. Harmon, would you give me a status report on the minority centers of excellence, your recruitment efforts, how far you have gone since we passed the bill last year?

Mr. Harmon. I believe that program is well underway and we are seeking to establish these centers.

Dr. Mullan would probably want to comment specifically.

Mr. Mullan. Yes.

Mr. Richardson, under the new legislation we have initiated a cycle of applications.

We have received 32 applications under the Hispanic-Native American and Other Centers of Excellence portion of that legislation.

Twenty-two of those centers have been Hispanic; 8, Native American; and 2 other centers.

A peer view process is underway and awards will be made in the near future.

We anticipate that there will be something on the order of six or seven Hispanic Centers awards made for a total of $2.5 million and about 4 Native American awards made for a total of about $1 million.

Mr. Richardson. This is a good start, but what are the projected plans for the next 5 years?

This is a rather modest effort. Do we have a budget problem?

Mr. Mullan. The administration's budget for fiscal year 1992 calls for a modest increase in appropriations for all of the Centers of Excellence programs, and we would anticipate that this support would be a strong part of the administration's budget proposals in years to come.

Mr. Richardson. Thank you, Mr. Chairman.

Mr. Waxman. Thank you, Mr. Richardson.

Gentlemen, we appreciate your testimony and we look forward to working with you on this legislation.

[Questions from Mr. Waxman and answers from Health Resources and Services Administration follow:]

HEAL Program

(1) What percentage of the HEAL defaults are due to bankruptcy? Is there abuse of the use of bankruptcy as a means to avoid paying these student loans? If so, how should the Public Health Service Act be changed to prevent abuse?

Please include information for the two most recent fiscal years on the number of defaults paid by DHHS that were due to bankruptcy.

Answer: Approximately 20 percent of the HEAL claims are due to borrowers filing for bankruptcy. Although there is no way to prevent an individual from filing for bankruptcy, HEAL borrowers have been largely unsuccessful in using bankruptcy as a means to avoid paying these student loans, due to an existing provision of the Public Health Service Act which makes it extremely difficult to discharge a HEAL loan due to bankruptcy. Accordingly, no changes are needed in the Public Health Service Act to prevent abuse. It should be further noted that the HEAL regulations currently allow lenders to file a claim as soon as they receive court notice that a borrower has filed for bankruptcy, even though the HEAL loan generally is not eligible for discharge. The Administration is in the final stages of amending the HEAL regulations to require lenders to hold the HEAL loan if a borrower files for bankruptcy under Chapter 7 of the Bankruptcy Code, and to continue pursuing collections upon completion of the bankruptcy proceedings. It is expected that this will significantly reduce the claims filed due to bankruptcy, since Chapter 7 bankruptcies have accounted for approximately 60 percent of the bankruptcy claims filed in the 2 most recent fiscal years.

For the 2 most recent fiscal years, the number of claims paid by DHHS that were due to bankruptcy are as follows:

Fiscal year	Number	Dollar value
1990	255	$10.5 million
1989	159	$6.9 million

(2) After the litigation and postjudgment collection requirements are met, the lender/holder is paid by DHHS. Most of the defaulters of HEAL loans are or will become health care professionals. Although their earnings are constrained during residencies and during their initial years of practice, many of these individuals will eventually earn substantial incomes.

Why are defaults occurring? Are incomes of health professionals inadequate to repay their student loans? Is income inadequate for a period of time at the beginning of repayment? Are defaults due to failure to complete training significant? Are technical defaults (re: failure to file a deferral form) significant factors in total defaults?

Please explain the methodology used in gathering information to answer this question.

Answer: A 1988 survey Of HEAL defaulters showed inadequate income at the time repayment begins as the number one reason borrowers default. Major reasons cited for inadequate income included licensing delays, the high costs of practice startup and business/practice financial problems. These results would indicate that, at least for some health professionals, income might be inadequate at the beginning of repayment to sustain HEAL loan payments. Borrowers do have graduated repayment options and may request forbearance for up to two years to overcome temporary financial difficulties, and substantial numbers of borrowers make use of these HEAL loan program features. Approximately eight percent of all defaults are by borrowers who have failed to complete their health professions educations. While the specific percentage of defaults which are technical defaults is not known, technical defaults are known to occur, and DHHS has taken steps to minimize technical defaults. In particular, special efforts have been made, working with health professions associations, to identify delinquent borrowers in the litigation process who should actually be in deferment. Further detection of potential technical defaults occurs at the time a claim is submitted for payment. At that time, verification is sought that the borrower is not in a deferrable status.

The information used to answer this question was derived from the results of a 1988 survey of HEAL defaulters on the reasons for defaults, as well as from Health Resources and services Administration [HRSA] financial operating reports.

(3) To what extent are losses to the Student Loan Insurance Fund due to defaults or to the failure to pursue judgments in later years?

Please provide for fiscal year 1989, 1990, 1991 and projected 1992 losses to the Student Loan Insurance Fund. Provide this information for each type of health profession school.

Answer: Approximately 70 percent of all claims paid have been defaults. Defaults which occur in later years, i.e several years after a borrower enters repayment, have not been a major default activity to date. Current data shows that 85 to 90 percent of all defaults to date occur within 3 years of entry into repayment. On a cumulative basis, however, it is expected that later defaults will make up a more substantial portion of the total as the 33-year life cycle of a HEAL loan continues. Judgments are pursued in later years if it is determined that the pursuit of a judgment immediately after paying a default claim would not be productive.

Claims by health professions discipline, by thousands of dollars, are provided in the following table for the years 1989, 1990, 1991 and 1992:

Discipline	Fiscal year 1989	Fiscal year 1990	Fiscal year 1991 (est.)	Fiscal year 1992 (est.)
Chiropractic	$2,900	$9,257	$16,096	$20,811
Allopathy	2,300	6,002	10,436	13,494
Dentistry	2,300	5,294	9,205	11,902
Podiatry	1,400	2,825	4,912	6,351
Osteopathy	700	1,468	2,553	3,300

Discipline	Fiscal year 1989	Fiscal year 1990	Fiscal year 1991 (est.)	Fiscal year 1992 (est.)
Other	500	1,264	2,198	2,842
Total	10,100	26,110	45,400	58,700

(4) For fiscal years 1989-91 please provide data on the number of HEAL defaults and their dollar value referred to the Department of Justice for collection.

For fiscal years 1989-91 please provide the percentage of HEAL loans on which the Department of Justice [DOJ] has taken action and the amount that has been recovered by DOJ.

Answer: For fiscal years 1989-91 the number of HEAL defaults and their dollar value referred to DOJ for collection were as follows:

Fiscal year	Number	Dollar value
1989	N/A	N/A
1990	294	$10.4 million
1991 (through 3/31/91)	797	$37.5 million

Data is not available on the percentage of HEAL loans on which DOJ has taken action for fiscal years 1989-91. However, the following table indicates the number, dollar value, and amount recovered on claims in repayment status at DOJ at the end of fiscal years 1989-91:

Fiscal year	Number	Dollar value	Amount recovered
1989	281	$6.7 million	Not available
1990	341	$9.7 million	$1.7 million
1991 (thru 3/31/91)	507	$17.3 million	$1.0 million

(5) To what extent are shortfalls in the Student Loan Insurance Fund due to lower SLIF payments charged in the early years of the program?

Answer: The approximate amounts of HEAL loans made at various premium rates through Fiscal Year 1990 are shown below:

Rate	HEAL lending
One-quarter of 1 percent per year of in-school and grace (0.75 percent effective flat rate)	$178.5 million
One percent per year of in-school and grace-(3 percent effective flat rate)	$398.1 million
Two percent per year of in-school and grace-(6 percent effective flat rate)	$525.8 million
Eight percent flat rate	$1,052.4 million

Eight percent of the HEAL loans in repayment have not been repaid and have resulted in claims against the insurance fund. An 8 percent insurance premium since the program's inception would have reduced, but not eliminated, the potential SLIF shortfall, due to the accrual and compounding of interest.

(6) Are you aware of other Federal loan programs that use their own attorneys or outside contractors to pursue defaulted loans? Please identify such programs and provide information on their relative effectiveness.

In this regard, dies the Department of Justice have authority to hire outside attorneys for debt collections? If got is DOJ using this authority for the REAL program?

Answer: We are not aware of other Federal loan programs that use their own attorneys or outside contractors to take legal action against borrowers who are in default. It is our understanding that only the Attorney General is authorized to take legal action against debtors who have defaulted on loans owed to the Federal Government.

It is also our understanding that DOJ has authority to hire outside attorneys for debt collections, and has used this authority on a pilot basis (i.e., in 7 out of 94 jurisdictions) for the HEAL program.

(7) To what extent are SLIF payments charged to students of one health profession subsidizing the defaults of students from another health profession? What would be the effect of individually adjusting the SLIF rate to reflect the relative default rates of each class of health profession school?

Answer: The extent to which SLIF payments charged to students of one health profession subsidize the defaults of students from another health profession can be estimated by looking at the following data, which indicates, by discipline, the total amount of insurance premiums that have been paid into the SLIF compared with the total amount of claims filed against the SLIF as of September 30, 1990:

Discipline	Insurance premiums paid	Claims paid
Allopathy	$49.0 million	$28.6 million
Osteopathy	$19.6 million	$8.1 million
Dentistry	$20.8 million	$31.1 million
Chiropractic	$16.8 million	$38.8 million
Podiatry	$10.0 million	$14.7 million
Other	7.3 million	$8.2 million

Adjusting the insurance premium rate to reflect the relative default rates of each discipline would be a more equitable way of assessing this charge, but would also be very costly for students in the disciplines with the highest default rates.

Mr. WAXMAN. Our next panel will comment on some of the controversial issues raised by the President's budget proposal to phase out the HEAL program.

Our witnesses will be Gerard W. Clum and Sid Williams, representing the Association of Chiropractic Colleges; and Kurt Hegetschweiler, representing the American Chiropractic Association; Anthony J. McNevin, representing the American Association of Colleges of Podiatric Medicine.

We are pleased to welcome you to the hearing.

Your prepared statements will be entered into the record.

Please limit the oral presentation to no more than 5 minutes.

Mr. Clum.

STATEMENTS OF GERARD W. CLUM, PRESIDENT, ASSOCIATION OF CHIROPRACTIC COLLEGES, ACCOMPANIED BY SID E. WILLIAMS, CHAIRMAN, LEGISLATIVE TASK FORCE; KURT HEGETSCHWEILER, CHAIRMAN, COMMISSION ON LEGISLATION, AMERICAN CHIROPRACTIC ASSOCIATION; AND ANTHONY J. McNEVIN, PRESIDENT, AMERICAN ASSOCIATION OF COLLEGES OF PODIATRIC MEDICINE

Mr. CLUM. Thank you, Mr. Chairman.

We appreciate the opportunity to be here today with you to discuss the concerns of the Association of Chiropractic Colleges relative to the budget proposal as it reflects on the HEAL program.

We are in opposition to the budget proposal to remove the HEAL program and to stop the program after so many years of activity.

We feel that the responsibility of the association is to bring to this table today and to your attention a series of reforms that would assist you in crafting a better and more functional program for all of the persons involved, for the students at Chiropractic Colleges, for the daughter of Mr. and Mrs. Smith, referenced by Mr. Kostmayer, and for all of the persons who have participated in the program.

One of the most important considerations is an extension of the deferment period or the initial time frame before which repayment of the loans begins.

If you look at the reports from the Bureau of Health Professions, it is obvious that the major problem that leads to default is the time frame between earning reasonable income to be in a position for prepayment and the start of the repayment cycle itself.

With the addition of a 1-year deferment period that would precede the existing 9-month period, we feel that this would be a reasonable approach to allowing the individual to establish themselves in practice and be in a position for meaningful repayment.

It was pointed out earlier that the groups of pediatric students, chiropractic students and dental students have more serious repayment default concerns.

These are students impacted by the time frame problem.

They enter private practice directly and as a result are most impacted by the timing sequence.

The second consideration is the involvement of chiropractic students in the HPSL program.

At the present time, they do not have access to the HPSL program.

As a result, the loan of last resort, which was the HEAL loan, becomes very economically a loan of first resort in that the HPSL program is a more cost-effective program, it is less burdensome to the students, and it provides for the opportunity for the student to provide funding for their education in a less burdensome fashion.

The third factor has been spoken of this morning, although not the jurisdiction of this committee, but the increase in the SLS program.

We feel that that would be a significant factor in helping to ease the dependence on HEAL and, therefore, help rectify some of the problems that have existed with the program itself.

The final consideration that the Association would like to bring to your attention is the standardization of default rate calculation.

There has been a great deal of discussion and comment over the past year on default rates in all loan programs for students and one of the problems is that we encounter is that the Stafford program, for example, their method of default calculation is different than the HEAL program and when you sit down to compare apples and oranges, it is very difficult to do.

We propose that standardization of the default rate basis would be an appropriate move to give you greater oversight capacity and greater ability to understand what the status of the individual programs is when they are compared to one another.

The other considerations that I would ask, that when you consider the question of the dollars or the percentages of the program that chiropractic students are involved in that are in default compared to other disciplines at this time, one of the most important aspects that has to be considered is the percentage of chiropractic loans that are in repayment versus the percentage of loans of other disciplines that are in repayment.

At the present time, approximately 47 percent of all loans made to chiropractic students are in repayment as opposed to 19 percent of loans made to students at Allopathic Institutions?

As a result, when one starts to compare the dollars in default, they are skewed tremendously.

If the playing field was level and the calculation brought out to what the number would be when 47 percent of each group is in repayment as chiropractic is then the number situation would be more equitable and would not be as marked as it appears to be in the budget proposal that has already come out.

Mr. Chairman, at this time, I would like to ask that the remaining time that I have be allotted to Dr. Sid Williams. He is chairman of the Legislative Task Force of the Association of Chiropractic Colleges and chairman of the Board of Directors of the International Chiropractors Association.

[The prepared statement of Mr. Clum follows:]

Prepared Statement of Dr. Gerard W. Clum, President, Association of Chiropractic Colleagues

On behalf of the Association of Chiropractic Colleges [ACC] and the nearly 10,000 students currently attending our member institutions, I wish to thank the Committee for this opportunity to provide information on the federal student loan issue from the unique perspective of the chiropractic college community.

The Chiropractic Profession

Chiropractic is an efficient, cost-effective primary health care alternative which offers consumers and third-party payment agencies a drug-free, nonsurgical health care option that is highly inappropriate for a wide range of conditions. Doctors of Chiropractic, thanks to our present system of quality chiropractic education, are intensively trained in the basic sciences, anatomy, physiology, diagnostic procedures and public health issues, and are unique among primary health care providers in their curricular emphasis on the structure and mechanics of the human spine.

Chiropractic students have an average age of 27 years, 30 percent are married, and 30 percent are women. Our educational institutions are private colleges. The only federal support for chiropractic education is through the present limited provisions of the student loan program.

After the successful completion of established undergraduate prerequisites similar to those required in medical and dental programs, chiropractic students must complete a four year program of full time residential instruction at an accredited chiropractic college. Upon completion of this program, students are awarded a first professional degree as a Doctor of Chiropractic.

The process of obtaining a license to practice chiropractic begins with the qualifying examination conducted by the National Board of Chiropractic Examiners [NBCE]. The NBCE examinations are accepted in whole or in part by all 50 states and the District of Columbia, but the majority of states require additional examination in clinical competency and other areas before a state license is granted.

Public acceptance and consumer confidence in the chiropractic profession are at an all time high. As public understanding of the positive benefits of chiropractic care increases, so does the effective consumer demand for chiropractic services. For example, as the risks of routinely applied surgical solutions to common back problems become more clearly understood, and as the costs of such procedures continue to explode, the conservative alternative offered by chiropractic is being actively sought out by millions of Americans every year.

Recent research findings fully document the efficacy and appropriateness of the chiropractic alternative for a host of patient conditions. Furthermore, chiropractic strongly emphasizes patient responsibility, health education, prevention and health maintenance in a drug-free environment.

We in the chiropractic profession were dismayed, and indeed somewhat puzzled by the characterization of chiropractic recently published by the Bush Administration in their 1992 Budget proposal. Describing chiropractic as a "low demand" profession, this document gives an incorrect impression of the viability of chiropractic in today's confusing and increasingly competitive health care marketplace. It is very important to note that throughout its nearly 100 years of existence, the chiropractic profession has sustained itself almost entirely with private sector dollars. In 1991, the average; doctor of medicine will receive over half of his or her income from federal, state or local government payments. For the doctor of chiropractic, this figure is somewhere around eight percent.

If there is one primary health care profession that can point to private sector demand and to marketplace viability for economic validation, it is chiropractic. Every day, thousands of American consumers decide to spend money out of their own pockets for chiropractic services, when traditional medical care is available to them through insurance or government programs at a subsidized cost, or no cost at all. They make this choice because they believe in what chiropractic has to offer.

The HEAL Program and Chiropractic Education

We in the chiropractic college community find it difficult to understand how the elimination of one vitally important professional funding mechanism, the Health Education Assistance Loan [HEAL] Program, could, in any conceivable way, be in the best interest of the consuming public, which we in the health care disciplines strive to serve.

To help you understand why we hold this position, I wish to focus the attention of the committee on the exact context in which the chiropractic college student finds him or herself in the process of funding a professional education and to convey, in as clear and concise a way as possible, the vital importance of the HEAL Program to the chiropractic student and to the thousands of individual patients each one will ultimately serve.

When the HEAL loan program was initiated in 1976, it was viewed by all parties as the loan of last resort. It did provide significant borrowing capacity, but it carried a devastating interest rate which currently stands at T-Bill plus three percent (9.25 percent as of May 30, 1991).

For many disciplines, HEAL was the loan of last resort, due to the availability of other more favorable programs. Among these programs is the Health Professions Student Loan Program [HPSL], which carries an interest rate of 5 percent and allows borrowing to the level of tuition plus $2500 per nine month academic year. But for chiropractic students, who have been excluded from participation in HPSL and have had very few, if any, options, the HEAL program is the loan of first and last resort.

The HEAL Timing Problem for Chiropractic Graduates

It is this forced dependence on the HEAL Program that has contributed to some of the problems experienced by chiropractic students in the program. For chiropractic students, the HEAL Program has contained a critical design flaw from the very beginning. It reflects a standard medical model of education, providing deferrals for graduates during periods of internship and residency. This allows a graduate of a medical school to be licensed and earning meaningful income well before the person moves into repayment. On the other hand, a typical June graduate of a chiropractic college seeking to practice in California would be eligible for licensure examination in November, would receive the examination results in January or February, and would be required to begin HEAL loan repayment in March.

For those who doubt the impact of an inappropriate licensure/loan repayment cycle, one only needs to review the performance of chiropractic students in states where licensure is available immediately after graduation.

The best performance on HEAL loans in chiropractic is seen with the graduates of New York Chiropractic College. In New York, students are eligible to take the licensure examination during their last term. As a result, a successful candidate is licensed within days after graduation, as opposed to months in the example cited from California. The result is a lower default rate due to greater income potential.

Chiropractic Default Rates

We would like to make two important observations concerning chiropractic student default rates. First, in contrast to the statements made by the Office of Management and the Budget [OMB], chiropractic default rates are not the highest rates being experienced by the HEAL program. For example, in an October 1990 report issued by the Bureau of Health Professions' Division of Student Assistance, default rates were noted as follows: Public health, 15.7 percent; health administration, 11.7 percent; podiatry, 10 percent; chiropractic, 9.7 percent; dentistry, 7.7 percent; and medicine, 5 percent.

Chiropractic default rates relative to other professions are still overstated. We believe that as other professions, most notably medicine, reach the stage that chiropractic graduates have that have our relative position among the professions in terms of default rates will improve.

The second point we would like to make concerning chiropractic default rates is that through the efforts of our colleges, they have significantly improved over the last four years. Every year since 1986, chiropractic students have borrowed fewer HEAL dollars than the year before. Aggressive debt awareness and debt management strategies have been presented to chiropractic students across the country. As a result, yearly default rates have gone down in four of the last five years.

Further Reforms in the HEAL Program

As taxpayers and citizens we realize that current HEAL default rates must be improved beyond the reductions that we have made in the last four years. To this end, on behalf of the Association of Chiropractic Colleges, we urge, in the strongest possible way, that serious consideration be given to the following reforms: (1) Amend the provisions of the HEAL Program to provide all disciplines with a standard one year or more deferment before the tolling of the present nine month grace period. As previously discussed this reform would "level the playing field" and allow chiropractic graduates to establish themselves before beginning repayment.

(2) Access and appropriate funding be provided for the participation of chiropractic students in the Health Profession Student Loan [HPSL] Program.

(3) Increase the borrowing capacity for all eligible students under the supplemental loan to assist students [SLS] from the current $4,000 per year to $10,000 per year. An increase in the SLS borrowing capacity and inclusion in the HPSL Program would decrease dependence on the HEAL program and make it truly a 'last resort' option. These two reforms would increase chiropractic students access to programs that have both fairer interest rates (good for the students) and who have significantly lower default rates than the HEAL program (good for taxpayers).

(4) Standardize the process by which default levels are calculated in all federal student loan programs according to the process employed by the Department of Education. Part of the HEAL programs "default problem" stems from the method used to calculate the default rates. HEAL program default rates should be calculated in the same manner as other programs.

We believe the above requests are reasonable and serve the publics' interest. These reforms would result in increased access to health care, lower costs of health care due to lower educational funding costs and greater levels of student loan repayment.

A Devastating Reform

We are aware of a "reform" being prepared that would have a devastating effect on the HEAL program. The Department of Health and Human Services is preparing a regulation that would arbitrarily implement a cutoff level of default on an institutional or discipline basis. We ask you to thoroughly and carefully consider the wisdom of allowing that regulation to be implemented. Such a broad axe approach to this issue would serve to disenfranchise some of the most needy students in disciplines across the spectrum of health care. Minority and female students would be impacted to an extreme. We implore you to consider a moratorium on regulations regarding default rates and for you to continue to monitor the progress of the professions in dealing with this matter after the reforms suggested above are implemented.

To do our part, we pledge our continuing support in implementing default reduction programs at each of our Colleges. Federal assistance for chiropractic education provides a door of opportunity through which thousands of young men and women have passed into careers as health professionals and productive taxpayers. We implore you to keep this door open as wide and as obstacle free as possible.

We thank you for your consideration.

STATEMENT OF SID E. WILLIAMS

Mr. WILLIAMS. Thank you, Mr. Chairman and distinguished members of the committee. I take this great opportunity to represent the International Chiropractors Association. I appreciate the opportunity.

In this process of default rate reduction, the Congress has an important role to play. It is vitally important that the members of this committee recognize that there are critical flaws in the design of the HEAL loan program as it applies to chiropractic students.

We emphatically believe that the legislative correction of these inherent programmatic problems will allow the chiropractic profession to bring the HEAL default rate down to the impressively low levels we are recording in other student loan programs.

For example, the general student loan default rate for Life College, of which I am president, is below 3 percent.

What is urgently required is the amendment of the payback schedule to reflect the realities of the postgraduation process of obtaining a chiropractic license and establishing a practice, or securing employment in an existing chiropractic practice or institution.

This is a process that can easily take a full year, or perhaps even longer, depending on the time of graduation and the State in which the graduate is seeking licensure.

The HEAL loan payback schedule is designed to fit the circumstances of the typical medical school student, providing generous deferrals for graduates during periods of internship, residency and postgraduate study.

These are reasonable provisions, and we support their continuance.

However, in fairness, we call upon the Congress to deal with the chiropractic college graduate with the same sensitivity, recognizing the fact that it is routinely quite difficult and often quite impossible for chiropractic graduates to be licensed and in a position to earn a professional income 9 months after graduation.

To correct this unfortunate imbalance in the HEAL program, we urge the Congress to enact amendments to the current program to provide all disciplines with a standard 1-year deferment before the start of the present 9-month grace period.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much.

[The prepared statement of Mr. Williams follows:]

PREPARED STATEMENT OF SID E. WILLIAMS, CHAIRPERSON OF THE BOARD, INTERNATIONAL CHIROPRACTORS ASSOCIATION

I am pleased to have the opportunity to share with the Committee important information about chiropractic and our system of professional education, in the hope that you will better understand the importance of the Health Education Assistance Loan [HEAL] program not only to our students and practicing Doctors of Chiropractic in active practice, but ultimately to the consuming public as well.

For sixty-six years, the International Chiropractors Association has sought to set the highest technical, professional and ethical standards for the chiropractic profession. The primary means through which these goals have been addressed is through the system of chiropractic education. Quality education is, without question, the primary element essential to insure the delivery of quality service. This is as true in chiropractic as it is in medicine, dentistry or any other licensed health care profession.

Chiropractic educational standards are strict and demanding, requiring a thorough background in the basic sciences roughly equivalent to medical, dental and osteopathic programs and four years of fulltime, residential instruction in human anatomy, physiology, biology, biomechanics, chiropractic diagnosis, adjustive techniques, public health issues and chiropractic philosophy.

Chiropractic college students must complete a rigorous and uniquely specialized program of classroom and practical training that includes more than 2,000 hours of specific study of the anatomy, dynamics and biomechanics of the human spine and the nature, and components of the spinal subluxation complex. No other health care professional devotes this level of serious scientific study to the human spine. The process of adjusting the human spine to correct spinal subluxation(s) is chiropractic's unique contribution to health care.

Chiropractic students are thoroughly trained in the appropriate use of sophisticated diagnostic technology including x-ray, thermography, video-fluoroscopy and other state-of-the-art investigative technologies and procedures. The capacity to fully evaluate the health care needs of the chiropractic patient, including appropriate referrals to other health professionals, when necessary, is an important objective of chiropractic education.

Nearly 10,000 students attend the 14 chiropractic colleges accredited by the Council on Chiropractic Education [CCE]. CCE is recognized by the U.S. Department of Education and the Council on Post Secondary Accreditation [COPA] and is the world's oldest and most respected academic standards organization for chiropractic.

Most of our colleges have sought to further certify their academic strength by qualifying for recognition and accreditation by regional accrediting agencies. For example, Life College in Marietta, Georgia, is additionally accredited by the Southern Association of Colleges and Schools and Palmer College in Davenport, Iowa, is accredited also by the North Central Association of Colleges and Schools.

Chiropractic educational institutions operate largely without the benefit of federal or other public grant monies. The chiropractic profession is unique among licensed primary health care professions in that its educational system has historically been funded almost entirely through private sources. Despite this unfortunate and inequitable handicap, the system of chiropractic education has, in recent years, grown dramatically and developed both in size and in the quality of the programs offered as well as in the professional excellence of its graduates.

Research into the fundamental components of chiropractic science and the efficacy of chiropractic care is an important element in the mission of U.S. chiropractic colleges. Again, without public funding on any significant level, chiropractic colleges engage in wide-ranging health research activities at the highest technical and professional level.

This is the world a new student encounters when he or she enters chiropractic college. However, a demanding curriculum and high academic standards are not the only challenges facing these young people. Finding the money to pay for a professional health care education is becoming increasingly difficult. It is somewhat disheartening to appear before you today for discussions on the future of federal funding programs for health education, in the context of the Administration's proposal to eliminate one of the most effective and important of the publicly funded assistance options available to people seeking a professional health education.

We at the International Chiropractors Association were deeply disturbed by the proposals made by the Bush Administration in their 1992 Budget regarding the elimination of the Health Education Assistance Loan [HEAL] Program. We were equally alarmed by the Administration's plan to expressly exclude chiropractic and podiatric students from the programs proposed to fill the void left by HEAL's termination.

It would appear that the reasoning behind the Administration's proposal regarding HEAL is based on an inaccurate or incomplete understanding of the chiropractic situation, particularly with regard to the default rate.

The chiropractic college community shares the Administration's concern over the issue of HEAL loan defaults. Reducing this rate has been and continues to be one of the highest priorities of our college administrators, myself included. Sound debt management programs, debt awareness education, the aggressive pursuit of alternative funding sources and enhanced practice and business management assistance programs have combined to both reduce the amount of new HEAL dollars borrowed, and to bring the yearly default rates down in four of the past five years.

We are working hard to make the HEAL loan the option of last resort that it was intended by Congress to be. We are proud of the progress we are making. We also realize there is much work yet to be done.

In this process of default rate reduction, the Congress has an important role to play. It is vitally important that the members of this Committee recognize that there are critical flaws in the design of the HEAL loan program as it applies to chiropractic students. We emphatically believe that the legislative correction of these inherent programmatic problems will allow the chiropractic profession to bring the HEAL default rate down to the impressively low levels we are recording in other student loan programs. For example, the GSL [General Student Loan] default rate for Life College, of which I am President, is below three percent.

What is urgently required is the amendment of the payback schedule to reflect the realities of the postgraduation process of obtaining a chiropractic license and establishing a practice, or securing employment in an existing chiropractic practice or institution. This is a process that can easily take a full year, or perhaps even longer, depending on the time of graduation and the state in which the graduate is seeking licensure.

The HEAL loan payback schedule is designed to fit the circumstances of the typical medical school student, providing generous deferrals for graduates during periods of internship, residency and postgraduate study. These are reasonable provisions, and we support their continuance. However, in fairness, we call upon the Congress to deal with the chiropractic college graduate with the same sensitivity, recognizing the fact that it is routinely quite difficult and often quite impossible for chiropractic graduates to be licensed and in a position to earn a professional income nine months after graduation. To correct this unfortunate imbalance in the HEAL program, we urge the Congress to enact amendments to the current program to provide all disciplines with a standard one year deferment before the start of the present nine month grace period.

We also have serious concerns about the way in which default records and aggregate default statistics are calculated in HEAL. We understand that once a chiropractic loan is recorded as being in default, it remains in that category even if the recipient repays the obligation in full. Clearly this type of procedure makes for a distorted picture of the true repayment situation. We urge the Congress to standardize the process by which default levels are calculated in all federal student loan programs according to the methodology utilized by the U.S. Department of Education.

To truly make HEAL the funding option of last resort, we urge the inclusion of chiropractic students in other federal programs, such as the Health Professions Student Loan Program [HPSL], and the expansion of the borrowing capacity for eligible students in the Supplemental Loans for Students [SLS] program. We urge the Congress to seriously consider the importance of these program changes in addition to the HEAL program reforms outlined above.

Finally, it is important to address the Administration's contention that the HEAL program does little to assist disadvantaged and minority students to obtain a professional health education. While we are in no position to offer data on other professions, in chiropractic education, HEAL is without question the primary means by which minority enrollment is underwritten.

Doctors of Chiropractic in general and the ICA in particular are committed to the establishment of a chiropractic profession in the U.S. that reflects the differences and diversity in our society. For many years, ICA has funded a minority scholarship program, in cooperation with the American Black Chiropractors Association, and ICA affiliated colleges have led the way in minority recruitment, including assistance in obtaining preprofessional educational requirements. The HEAL Program has served to fund the professional education of the vast majority of Hispanic, Native American, Asian and African American chiropractic students when other avenues of public funding were closed and when private resources were not adequate or not available at all.

The elimination of the HEAL Program and the arbitrary exclusion of any health profession from the HPSL Program or any other federal assistance program will serve only to slam another door in the faces of able, intelligent, courageous young men and women who want nothing more than the opportunity to work and to strive as health care professionals.

In closing, I urge the Committee to consider all those HEAL loan borrowers who do successfully repay their obligations, in full and on time. Their achievements, in the face of genuine adversity and at great cost because of the high interest rates and premiums attached to the HEAL loan are a national success story, in chiropractic and in all the other professions. Their entry into America's pool of health personnel has helped to keep national health care costs down and played an important role in meeting the growing need for quality service in a health care delivery system under serious pressure.

On behalf of the officers, directors and membership of the International Chiropractors Association, which includes nearly 3,000 chiropractic college students, I wish to thank the Committee for this opportunity to present our perspective on this vitally important issue. We will be happy to provide any additional information you may require and to answer any questions you may have.

Mr. **Waxman**. Now, let's hear from Mr. Hegetschweiler.

STATEMENT OF KURT HEGETSCHWEILER

Mr. **Hegetschweiler**. Thank you, Mr. Chairman, for providing the American Chiropractic Association to testify on the issue of Federal student loans.

Mr. Chairman, the issues which we are addressing today deserve a serious and thorough analysis. Although a full understanding of the HEAL loan program requires a detailed examination of many technical issues—the message we wish to deliver today is very simple:

One, the HEAL program serves many admirable and important policy objectives, and as such, deserves to be continued.

Two, the default rates in the program are unacceptably high—and Congress should address this problem through the enactment of meaningful legislative reform.

Three, no single health care profession, or group of professions, should be singled out for punitive treatment which would bar them, as a class, from participation in the program.

All institutions, regardless of profession, should remain eligible to participate in the program, as long as they remain in compliance with any new eligibility standards established by Congress.

All institutions should be treated fairly and should be made to adhere to the same rules and regulations—regardless of profession.

Mr. Chairman, we categorically reject the OMB position on this matter, as stated in their fiscal year 1992 budget submission.

The recommendation, to exclude the chiropractic profession from the HEAL program, was an unfortunate method by which to solve a complex public policy issue and constitutes little more than gratuitous "profession-bashing."

In any other arena, OMB's choice to delete an entire class of providers or group of professionals from a Government program would have been seen as discriminatory and as such totally unacceptable.

In attempting to address the legitimate concerns about the HEAL program, the American Chiropractic Association has tried to play a constructive and positive role, by helping to craft a series of possible program reforms which could be instituted.

We have included a suggested list of reforms as an attachment to this testimony for your review.

We have made a good faith effort to craft reforms which are all inclusive, and we believe we have offered substantial and credible suggestions.

We do not claim that our list of possible reforms is perfect—however, it would seem reasonable to assume that if this committee were to positively signal its strong intent to reform the program—rather than abolish it—then other parties might be encouraged to develop helpful reform suggestions as well.

We encourage any constructive dialogue which might result from this approach. Whatever Congress does, it should be guided by two principles: fairness and incentives to all participants in the program.

I wish to make one point absolutely clear. We recognize and fully accept the legitimate need to address the problem of unacceptably high default rates within our profession.

We do not seek to evade or shift the emphasis off the compelling need to address this problem.

We fully support the imposition of needed reforms to the HEAL program—which will strengthen—not weaken the program in order to guarantee that the program continues to fulfill those policy objectives for which it is intended, by providing continued access to a critical source of student loan funds for students of all health care disciplines, including chiropractic.

One of the major reforms which has surfaced involves the establishment of a default rate cap—or other capping mechanisms, which would preclude institutions with excessively high default rates from participation in the program.

We have no problem supporting this concept, as long as any capping mechanism or rate is applied equally to all institutions, regardless of discipline.

The actual capping rate, which might be established and the mechanisms used to define or compute default rates are a matter of concern to our profession.

Any cap established should be both realistic and consistent with meeting the public policy needs and objectives of the program.

Before concluding our testimony, I would like to make note of the following observations which we feel should be given consideration by the committee in its deliberations:

One, an incentive-based system to encourage institutions to bring down their default rates should be enacted. Systematic exclusion from the HEAL program or other draconian measures do nothing to encourage the many schools with low HEAL default rates from continuing their work to bring default rates down. One idea is to establish a differential insurance premium rate and allow a 3- to 5-year phasein to bring down the default rate to an acceptable level.

Two, all eligible provider groups should be treated equally across the board.

Three, default rates should be calculated on a cohort basis similar to the Department of Education calculations.

Four, while we feel current chiropractic default rate are unacceptable, other classes of providers have a higher percentage of defaulting students or a comparable percentage rate.

Five, all HEAL eligible disciplines should be less expensive HPSL loan program.

It makes sense that students who are paying higher rates are having more difficulty repaying their student loans.

Put all disciplines on the same playing field before comparing them. Provide additional incentives. If an institution meets the HPSL standards, the institution should be eligible.

End the professionwide exclusion of chiropractic from HPSL; that is not only fair, but adds incentives to schools to continue to bring down their default rates.

Mr. **WAXMAN**. The rest of that statement will be in the record. Your time has expired.

I have to respond to a vote on the House floor, so I will recess the meeting now and if Mr. Kostmayer comes in we will get started again and I will return as soon as I can.

[Testimony resumes on p. 73.]

[The prepared statement and attachment of Mr. Hegetschweiler follow:]

TESTIMONY OF
KURT HEGETSCHWEILER, D.C.
CHAIRMAN, COMMISSION ON LEGISLATION
AMERICAN CHIROPRACTIC ASSOCIATION

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Three -- No single health care profession, or group of professions should be singled out for punitive treatment which would bar them -- as a class -- from participation in the program. All institutions, regardless of profession, should remain eligible to participate in the program, as long as they remain in compliance with any new eligibility standards established by Congress. All institutions should be treated fairly and should be made to adhere to the same rules and regulations -- regardless of profession.

Mr. Chairman, we categorically reject the OMB position on this matter, as stated in their FY92 Budget submission. The recommendation, to exclude the chiropractic profession from the HEAL program, was an unfortunate method by which to solve a complex public policy issue and constitutes little more than gratuitous "profession-bashing." In any other arena, OMB's choice to delete an entire class of providers or group of professionals from a government program would have been seen as discriminatory and as such totally unacceptable.

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Whatever Congress does, it should be guided by two principles: fairness and incentives to all participants in the program.

I wish to make one point absolutely clear. We recognize and fully accept the legitimate need to address the problem of unacceptably high default rates within our profession. We do not seek to evade or shift the emphasis off the compelling need to address this problem. We fully support the imposition of needed reforms to the HEAL program -- which will strengthen -- not weaken the program -- in order to guarantee that the program continues to fulfill those policy objectives for which it is intended, by providing continued access to a critical source of student loan funds for students of all health care disciplines -- including chiropractic.

One of the major reforms which has surfaced involves the establishment of a default rate cap -- or other capping mechanisms, which would preclude institutions with excessively high default rates from participation in the program. We have no problem supporting this concept, as long as any capping mechanism or rate is applied equally to all institutions, regardless of discipline. The actual capping rate which might be established and the mechanisms used to define or compute default rates are a matter of concern to our profession. Any cap established should be both realistic and consistent with meeting the public policy needs and objectives of the program.

Before concluding our testimony I would like to make note of the following observations which we feel should be given consideration by the committee in its deliberations:

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- All eligible provider groups should be treated equally across the board.

- Default rates should be calculated on a cohort basis similar to the Department of Education calculations.

- While we feel current chiropractic default rates are unacceptable, other classes of providers have a higher percentage of defaulting students or a comparable percentage rate.

- All HEAL eligible disciplines should be part of the less expensive HPSL loan program. It makes sense that students who are paying higher rates are having more difficulty repaying their student loans. Put all disciplines on the same playing field before comparing them. Provide additional incentives: if an institution meets the HPSL standards, the institution should be eligible. End the profession-wide exclusion of chiropractic from HPSL; that is not only fair but adds incentives to schools to continue to bring down their default rates.

- Allow forgiveness of the loan if one provides service in a designated medically underserved area, a certain amount for each year served. 29% of ACA's members practice in communities with populations of 25,000 or less. These are the types of communities that need portal of entry health care providers like doctors of chiropractic.

- A chiropractic-specific amendment to allow an additional one-year grace period is needed so that practioners have enough time to set up a practice and become established prior to repayment commencement. Other disciplines have their residency and internship grace periods and this provision would be comparable.

In conclusion, Mr. Chairman, I would like to reemphasize that the American Chiropractic Association strongly feels that the reauthorization of the HEAL loan program and the issue of default rates can be dealt with successfully -- through common sense and good faith reforms which are fair to all parties involved. Towards this end, we have engaged in a productive dialogue with as many of the key players involved as possible. We have met privately with departmental officials in charge of administering the program, members of Congress and their staffs, college administrators, student participants in the programs. associations representing other professions, and other parties interested in the HEAL loan program. For us, this has been an encouraging process, as we have been told time and time again, that we're on the right track. Our profession has a compelling need to participate in the HEAL and HPSL programs -- and we are sincere in our strong desire to see that those student loan programs to which we have access are fiscally responsible and sound, so that they can continue to fulfill the important policy objectives for which they were intended. In this regard, we stand willing to do our part and to continue to work with others towards a positive common objective.

We thank the subcommittee for its indulgence, and its willingness to provide us with an opportunity to present our views on this important matter.

1991 HEAL REFORM SUGGESTIONS

Among the proposals and suggested reforms in this list are strategies aimed at many of the complex factors and policies which contribute to students defaulting on their HEAL loans. While this list is not assumed to be all-inclusive, we feel it offers many substantive solutions to the HEAL default problem. These proposals cover many differing aspects leading to student defaults, some require legislative action, some can be achieved through regulation, and others can be achieved by the educational institutions and organizations representing each profession. These reforms are not chiropractic specific just as the default problem is not profession-specific but rather is an institution by institution concern. We believe that all parties involved, colleges, lending institutions, professional organizations, and policy-makers should take responsibility to effect reform within their sphere to return this valuable program to financial solvency and budget-neutrality.

LEGISLATIVE/REGULATORY REFORMS

o **Simplify loan process by allowing lending institutions to consolidate HEAL loans with other student loans**

HEAL loans may currently be combined, but not consolidated with other loans. The book keeping process needs to be streamlined for lending institutions in order to simplify the collection of loans as well as helping to encourage the repayment of loans by allowing the borrower to make one easy payment.

o **Institute an early intervention program through outreach efforts**

During the crucial interval between graduation and the beginning of the repayment schedule a stepped-up educational intervention program must be put into place. Students who find themselves in a financial bind and are unable to pay should be educated about alternatives available to them. A helpful "hotline" manned by the educational institutions, lenders, or the Department of HHS can assist in keeping an open dialogue with such former students. Educational materials explaining options should be made available.

- **Allow a one year deferment before grace period for students of disciplines not eligible for internship or residency deferment.**

  Currently many HEAL borrowers do not even have the opportunity to sit for licensure prior to the arbitrary deadline for initiation of repayment. An additional one year deferment from repayment should be instituted for those health professions which are not eligible for deferment on the basis of a residency or internship program. This deferment period would allow the student sit for licensure, to establish his/her practice and be in a better position to repay the loans. Policies which set unfair deadlines making it more difficult for first-year practitioners to meet their obligations must be corrected.

- **Standardize the Departments of Education (USDE) and Health & Human Services default calculations. USDE procedures for Stafford program should be applied.**

  Standardizing the loan programs will allow for uniform reviews of the various programs and to properly assess those procedures which are working to reduce the default rates. Default rates for institutions should be calculated on a cohort basis rather than cumulatively, thus a more accurate representation of institution's progress toward lowering defaults would be clearly seen.

- **Provide eligibility for students of chiropractic in the HPSL program and alternative loan programs to make HEAL a program of last resort. With the 5% default cap under HPSL, this would provide market incentive for institutions to take corrective action.**

  All borrowers eligible for the HEAL program should be eligible for the HPSL program. The less expensive nature of the HPSL program will help reduce overall indebtedness, thus the HEAL program will be used only as a last resort.

- **Institute default rate performance standards at a percentage that would insure the solvency of the insurance fund (SLIF) (phased-in over a 3-5 year period).**

  A cap rate of default should be put in place to encourage schools to take positive action to collect on defaulted loans. The rate should take into account efforts of those institutions which are taking steps to reduce defaults. The performance standard should be phased-in with a procedure similar to that implemented under the HPSL program whereby an institution is permitted to retain loan eligibility if they succeed in lowering their rate by one-half until they are in compliance with the standard.

- **Mandate that lenders provide student borrowers who drop out of school a supplemental repayment agreement which bases the amount of the borrower's payments on his or her income.**

  The reauthorization should provide that HEAL program have flexibility to promulgate regulations which allow lending institutions to effectively renegotiate a new agreement with students who have dropped out basing the agreement with the borrowers current ability to pay. The lending institution should have the flexibility to readjust the agreement during the term of the note on the same basis of ability to pay.

- **Provide borrowers with the option of either serving in a geographic underserved area of the country or providing public service in return for forgiveness of a portion of their loan.**

  In a measure that would improve access to health care while providing an incentive for providers to locate in medically underserved areas, borrowers should be forgiven a portion of their indebtedness in return for practicing in a medically underserved area. Further, all borrowers eligible for the HEAL program should be eligible for service in the Public Health Service Corps.

- **Permit HEAL borrowers to refinance their loans. Borrowers would be required to pay the lender the market rate for refinancing.**

  In order to encourage HEAL borrowers to repay their loans, lenders should be allowed wide latitude to develop innovative repayment schedules.

- **The federal government should partially subsidize the time accrued interest on the loan while the borrower is in school and during periods of authorized deferments.**

  Recommended by the Bureau of Health Professions (BHPr) report "A Review of Defaulters..." Part II of November 3, 1985. This recommendation (#21) would reduce monthly payments for borrowers. Cost trade-offs between the amount of decreased defaults and the cost of such a subsidy are uncertain.

- **Support H.R. 747 which provides for the tax-deductibility of interest on student loans.**

  The tax deductibility of interest paid on student loans provides another incentive for repayment.

- **Encourage states to consider allowing students to sit for licensure during last trimester of college.**

  State legislation currently enacted in 20 states allows students to take their boards prior to graduation. This helps establish the borrower at an earlier time. Thus allowing him to establish and develop a practice prior to commencement of repayment.

- **Provide incentives to encourage lending institutions to aggressively pursue defaulters.**

  Currently there is little incentive for lending institutions to take an active interest in lowering default rates. These institutions have the experience and personnel necessary to have a significant impact on the collection of defaulted loans, but the current system discourages any interest in the problem.

INSTITUTION OR ORGANIZATIONAL EFFORTS

- **Develop educational booklets for all students outlining options**

  Educational institutions can be an effective distribution network for the HEAL program. A stepped-up distribution of educational materials during and immediately after graduation is needed. The government could design such a package and the institutions could print the necessary copies for its students.

- **Require follow up on defaulters by the educational institution**

  Schools should be encouraged to pursue their former students who are in default through mailings and other outreach efforts.

- **Have professional association write defaulters to urge their repayment.**

  State and national organizations should be able to contact defaulters to inform them of thier options, and help facilitate repayment. This would require that BHPr make the names and addresses of defualters available. Professions should be encouraged to aid in the collection process and by focusing attention on the issue of non-payment of loans.

- **Encourage colleges to withhold the transcripts of defaulters.**

  The law should permit colleges to withhold transcripts from defaulters.

- **Develop introductory consumer information to potential students during admissions process.**

  Consumer information for prospective students is an early preventive measure against default. A fact sheet outlining the loan programs as well as prospective living expenses and other costs should be made available during the admissions\ process to enable the prospective student to estimate costs and total indebtedness.

- **Print articles in professional publications about default problem and educate defaulters on the process to re-enter the repayment process.**

  A profession's publications can reach some parties who have not come into repayment. Thus publications can be used as another educational tool on how defaulters can be brought back into repayment.

- **Institute mandatory debt management workshops at each school**

  Debt management workshops which educate students on loan choices, budgeting, interest rates, and repayment obligations should be offered each semester/trimester Many lenders offer brochures and have trained student loan representatives which could be utilized in this regard.

We feel that the following recently adopted policies have not been enacted long enough to have had a measurable effect on default rates; we feel they should be continued.

- **Continue to report default information to the credit record.**

  Under relatively recent law a defaulting student's credit record would be adversely affected due to the reporting of the defaulted loan. This practice should be continued.

- **Continue attachment of tax refunds through IRS.**

  Tax refunds should continue to be attached when the taxpayer is in default on his/her student loan.

- **Continue mandatory litigation prior to claim payment.**

  The litigation process of lenders obtaining a court judgement against defaulters is only now beginning to have a statistical impact. It should be carried forward.

- **Eliminate the statute of limitations on penalizing defaulters.**

  Any remaining statute of limitations which defers lenders and governments from pursuing HEAL defaulters should be removed from the books.

- **Continue to garnish federal employees' wages.**

  Garnishment of federal wages is an effective tool for enhancing loan compliance and should be continued.

Mr. **Kostmayer** [presiding]. The subcommittee will come to order.

The chairman is on his way back.

I think you were next, Mr. McNevin.

STATEMENT OF ANTHONY J. McNEVIN

Mr. **McNevin**. Mr. Kostmayer, my name is Anthony McNevin. I am pleased to report to you that I am not an employee of the administration, rather I am the president of the American Association of Colleges of Podiatric Medicine.

The association represents the Nation's seven colleges of podiatric medicine and over 200 teaching hospitals throughout the United States.

Allow me to describe briefly the educational process in podiatric medical education because it explains, in large part, the reasons behind the problems we are addressing today.

The majority of students selected for admission into the colleges of podiatric medicine have completed 4 years of undergraduate work.

While an enrolled student at a college of podiatric medicine, they spend 4 years in a traditional medical program devoting the first 2 years to basic science education and the last 2 years studying clinical sciences.

Five of the colleges of podiatric medicine are freestanding institutions while two are part of private university health science centers.

Upon receiving the Doctor of Podiatric Medicine Degree, the graduate will continue his or her education in a residency program normally 1 year in duration and in a hospital setting.

Some of the graduates go on to 3 and 5 years of advanced clinical training; however, most complete a 1-year program and enter into practice immediately thereafter.

Not unlike other health disciplines, podiatric medical students rely significantly upon the HEAL program to finance their podiatric medical education.

In some cases, 75 percent of the students finance their education with HEAL loans.

In his fiscal year 1992 budget proposal, the President called for the demise of the HEAL program because he states the program, contrary to its original design, has not been self-supporting.

The President also proposes a revitalized Health Profession's Student Loan program, with less than modest capitalization, targeted toward disadvantaged student populations.

Within this context, he cites podiatric medicine as a "leader" in HEAL defaults, implies that the country is oversupplied with podiatric physicians and that podiatric medical schools do not enjoy the "public trust" and are therefore not "worthy of receiving taxpayer support."

It is difficult to acknowledge these comments in a gracious manner given the millions of patients, particularly elderly patients as well as U.S. veterans and Federal employees, who visit and benefit from the care rendered by podiatric physicians yearly.

In effect, the President's budget is saying that the Federal Government should not engage in supporting and assisting the many young people, particularly middle-class people, who embark upon a career in a healing profession like podiatric medicine.

I believe that the members of this subcommittee must feel the indignation that those in podiatric medicine experienced upon the promulgation of the President's budget.

We strenuously disagree with the President's proposal.

He is denying access to the primary source of capital which health profession students need to finance their education.

Podiatric medicine has been a participant in the HEAL program since its inception.

In fact, a proposal developed by the association served as the progenitor of the HEAL concept.

It is ironic, therefore, that the President is calling for the exclusion of the profession at this time.

Although an original participant, podiatric medicine represents a rather modest user of the program.

According to the Department's fiscal year 1990 report, since the beginning of the program only 8 percent of all disbursements have gone to podiatric students while 41 percent have gone to students in allopathic medicine, 15 percent to students in osteopathic medicine, 17 percent in dentistry and 14 percent in chiropractic medicine.

In claim rates, the podiatric profession falls behind chiropractic, allopathic, and dental medicine while the profession does not even rank high enough to be placed on the roster of the top 10 participating HEAL schools.

However, the very real tragedy about the HEAL program is its default rate.

Increasing claims against the program's insurance or SLIF fund are exceeding the balances in the fund.

In November 1989, the Congress appropriated $25 million to shore it up.

Although the Department has sought to address the matter in many ways, a definitive explanation for the phenomena is still to be told.

Again, and according to the Department's report, since the inception of the HEAL program, podiatric student borrowers paid $10 million into the insurance fund while the Department paid out $14.7 million in claims.

In the case of allopathic medicine, $49 million was paid in, $29 million paid out; in dentistry, $20 million as compared to $31 million and in the case of chiropractic medicine: $16 million versus $38 million.

Three years ago, the Association of Colleges of Podiatric Medicine recognized this problem and initiated a program with the Pennsylvania Higher Education Assistance Agency.

The program allows students in each of the seven colleges to obtain their HEAL loans.

The association chose this course of action because PHEAA enjoys an outstanding reputation in the field of student loan servicing.

However, the reason for this choice goes deeper.

The association has always found it difficult to impose upon its member colleges the responsibility for the total explanation for defaults among its graduates.

Defaults occur normally within the first 3 years beyond graduation.

In the case of podiatric medicine, where the majority of graduates spend 1 year in residency training, the obligation to begin the repayment of loans occur outside of an institutional setting.

In other words, by the time the student is at repayment, and many students are in repayment at much earlier times than other disciplines, he or she is out of the training and educational setting, attempting to establish a viable practice.

Under these circumstances, the options available to the borrower are not in the forefront of the borrower's mind.

We have discovered that students are generally ignorant of the scope of their financial obligations much less of the options available to them to successfully manage their indebtedness.

Recently mandated entrance and exit sessions with students advising them of their financial obligations will influence and, indeed, will help to bring down default rates across all professions.

According to reports from our colleges, the individuals who are defaulting at this time are those who took out loans in the early eighties when interest rates approximated 20 percent, when a credit check and a need analysis were not required, and the climate in the schools and in the Federal Government was less strident on defaults than it is today.

Couple these factors with the early entrance into practice and one begins to understand why the profession is experiencing a higher than wanted default rate.

We are convinced that our students, like all students who participate in the program, are honorable about their financial obligations and will do what is required of them to satisfy these obligations.

At the same time, we believe that much more can be done particularly in the school community.

Currently, there are 420 podiatric physicians who have defaulted on their HEAL loans; I am very pleased to report that 26 percent are back in repayment; unfortunately, 17 percent were required to file for bankruptcy.

This leaves a total of 238 individuals who are in actual default.

Regrettably, this information does not affect the default rate calculation produced by the Department.

Effecting constructive change in student loan programs is a process which requires patience because it normally takes 5 to 7 years to see the results of the changes. Although the association is sanguine about future declines in the podiatric HEAL default rate, I, as president of the association, have determined that much more needs to be done. This past year I have called for the establishment of a special task force to identify and assist in implementing effective strategies for student and practitioner debt management. The association's board of directors will establish the task force next Tuesday at its annual meeting.

I envision that the task force will investigate more thoroughly the specific reasons behind defaults and address questions like:

Should residency directors be trained to serve in the role of a financial aid officer? Should the college financial aid officer extend the scope of their responsibilities to the teaching hospital setting? Are there activities which he practice association can undertake to assist their members to fulfill their financial obligations? Are there specific areas in which financial aid officers need additional training? Can a national podiatric default management program be undertaken and managed through the association? What institution-wide strategies can be undertaken to stem the problem? What is the relationship between the cost of education and indebtedness? In a 1988 Department study on defaults, many health professionals reported that the burden of establishing a new practice and managing educational indebtedness as overwhelming. This area needs further study. Finally, ways must be found to reverse the reliance upon HEAL. Originally planned as a program of last resort, it has now become the primary source of financing a health professions education. Increased borrowing limits in Department of Education loan programs like the supplementary student loan program and the Stafford loan program may provide some assistance.

As you can see, the association is about to embark on a significant undertaking. The studies we will perform, some of which will be done in collaboration with the Bureau of Student Assistance, will, I am convinced, shed significant light on the nature of the default problem and generate ways in which it can be contained. If, on the other hand, the President's budget plan for student financial aid is implemented, the Congress will have effectively eliminated an entire health profession. I am convinced that this is not the objective of the subcommittee. In closing, I wish to remind the subcommittee that several years ago we addressed the same problems in the HPSL program. Defaults were rampant across all disciplines and the Department imposed a default threshold on all participating schools. In order to continue in the program, a school was required to meet a 5 percent threshold. If exceeded, it ran the risk of being excluded from the program. Within a brief number of years, all schools are now in compliance.

The HEAL program is different than HPSL. In the case of the latter, the schools are exclusively responsible for collections. In HEAL, the schools have no responsibility for collection. Taking into consideration a school's role in the program, as well as the role and responsibility of the other institutional participants, a reasonable default threshold can and should be imposed. I am convinced that the default rate will drop with it. However, I must emphasize the need for a reasonable default rate.

Thank you for this opportunity to present the association's point of view on this important matter. If you have any questions, I will be pleased to try to answer them.

Mr. Kostmayer. What is a reasonable default rate?

Mr. McNevin. Currently the Department has suggested that that rate should be 5 percent for HEAL for schools and they have tagged that rate very close to or identically with the HPSL program and I believe that that is fundamentally unfair given the scope of responsibilities that the schools have in the HPSL.

I suspect that a reasonable rate should be somewhere between 10 to 15 percent.

Mr. **Kostmayer**. The 5 percent is a departmental figure?

Mr. **McNevin**. That is what they have proposed in an interim regulation.

I would suggest somewhere around 15 percent.

Mr. **Kostmayer**. What is that going to cost the Federal Government?

Mr. **McNevin**. I don't have those calculations.

Mr. **Kostmayer**. Mr. Hegetschweiler, your testimony asks the Congress to look at the issue of default on the HEAL program through meaningful legislative reform.

As you know, this subcommittee and the Department have acted many times in the past to tinker and tamper and try to fix the HEAL program and it seems to get worse.

Even if we shut down the program tomorrow, the claims would be with us for many years.

Why shouldn't the Government just cut its losses now?

Mr. **Hegetschweiler**. First of all, as far as chiropractic education is concerned, it would be a disaster since that is the only Federal loan available to them.

Second, we feel if Congress can implement a little better repayment policy the HEAL loan program such as to allow the graduates to have some time, 9 to 12 months to establish their practice as they can in other fields then we don't need to have that abolished.

Mr. **Kostmayer**. You mean before repayment would commence?

Mr. **Hegetschweiler**. Yes.

Mr. **Kostmayer**. In this program, they have to commence repayment immediately upon graduation?

Mr. **Clum**. There is a 9-month grace period before repayment begins with the HEAL program under its current configuration.

The recommendation, I believe, of the American Chiropractic Association, as well as the Association of Chiropractic Colleges would be to add another 12 months to that to allow the practitioner the time to establish practice, 21 months, to functionally have a meaningful source of income.

Mr. **Kostmayer**. All of you have testified that some sort of performance standard or default cap is necessary to bring the program into line.

Representatives from the chiropractic schools have also asked to participate in the HPSL program.

The default rate cap on the HPSL program is 5 percent.

Do you have any objection to HPSL rate cap for HEAL, and if so, why? In other words, do you think it would be fair to be the same?

Mr. **Clum**. No, sir. The consideration that we need to look at in relationship to the HEAL program are the basic differences in design between HPSL and HEAL and the responsibilities of the parties involved, number one.

The second consideration would be the time frame that we would be looking at in relationship to these caps—are we talking about based on existing loans, new loans?

What are the parameters that we are looking forward to?

The other considerations include the method of calculation of default, are we going to stay with the method that is currently used by the bureau?

Could we move to the method that is used by the Department of Education to standardize it with all other loan programs that our students have access to, and to give you equality to judge the performance on those other programs.

So I don't believe that on behalf of the Association of Chiropractic Colleges that 5 percent is an anywhere near acceptable level for the implementation of a HEAL loan default rate.

Mr. **Kostmayer**. You think it ought to be more like what——

Mr. **Clum**. It is very difficult to put a number on it at this time given the variables that enter into the picture.

If we have the participation of the chiropractic student in the SLS program, the participation of the chiropractic student in the HPSL program?

We have the modification of the default method.

Those would all bear on the final number.

In relationship to everything being as it is today, it still becomes a very difficult number to put a handle on, and I don't believe that there is a consensus within the health disciplines for that number.

We would certainly welcome participation in development of that if that were the case.

Mr. **McNevin**. We may have some good suggestions that have come out of the Department of Education in terms of the way it has addressed the similar problems in the GSL program.

For example, the default rate in GSL is at a 30 percent level, very high.

As you compare the experience of institutions in that program against the HEAL program, I don't think that is necessary for HEAL.

At the same time, the regulations that govern GSL make it very clear that the Department is not interested in excluding professions or schools.

There are specific strategies laid out in the regulations that allow a school to cure itself, so to speak, to remedy the problems that it may be able to identify in an internal period to come back into compliance while still participating and allowing their students access to loans.

I think that is an extraordinarily reasonable approach to take, is less Draconian and I think more reflective of the social values that we would want to support in terms of education of our young people.

Mr. **Kostmayer**. Mr. Williams, what about the administration claims that the HEAL program doesn't benefit minority students?

I understand Dr. Herman Glass has provided testimony on the importance of the HEAL program for minority chiropractic students.

Would you summarize that?

Mr. **Williams**. Yes, I will. Thank you, Mr. Kostmayer.

This is a statement by Herman Glass, President of the American Black Chiropractors Association.

On behalf of the nearly 400 members of the American Black Chiropractors Association, ABCA, the hundreds of other minority students presently in chiropractic colleges and the many thousands who in years to come will seek to pursue a chiropractic education, I urge this committee to preserve the HEAL loan program and chiropractic participation in it and all other Federal health education assistance programs.

According to the budget for fiscal year 1992, part 2, page 140, "HEAL was originally intended to provide financial relief to students in high-tuition medical schools and assure disadvantaged students access to health professions educations."

While we cannot speak to the issue of medical schools, we can, from our unique perspective, assure the committee that HEAL has indeed been primary key to minority access to a chiropractic education.

A preliminary survey of our membership indicates that well over half of all African-American Doctors of Chiropractic obtained their professional education through a HEAL loan. Among recent graduates, the proportion is even higher.

We respect and appreciate the commitment the chiropractic college system has shown to equal opportunity and to minority outreach.

We are pleased by the aggressive efforts of institutions such as Life College in Marietta, Ga., which has established the first Office of Minority Recruitment within the chiropractic college system, and which has implemented the second Health Careers Opportunity Program for disadvantaged and minority students.

Because of Federal assistance, Life College has the largest number of minority students in chiropractic education. Such programs can provide a start. HEAL provides the means by which minority students can finish their chiropractic education.

We look to you in the Congress to be a partner in the process of professional opportunity for all minorities. What good is the open door offered by the chiropractic profession if policymakers choose to slam it shut by denying realistic funding assistance?

The HEAL loan program is not a handout or a giveaway program. HEAL borrowers pay dearly for the privilege, at the highest rate of all Federal education loans, working hard to earn the money to repay those loans.

HEAL represents a genuine means by which hard-working, dedicated young citizens, from all backgrounds and circumstances, can help themselves to a better life, in service to a Nation urgently in need of compassionate, accessible health care providers.

We understand that there is a genuine concern over the default rate among chiropractic borrowers under the HEAL guarantee program. We share that concern and are working hard to encourage and assist our members to meet their HEAL loan obligations. We strongly support the aggressive program that the chiropractic colleges have undertaken to bring the default rate down, and we are pleased by the dramatic success these efforts have achieved.

However, we strongly believe that much of the default problem could be quickly eliminated by providing a realistic payback schedule, allowing enough breathing space for a chiropractic graduate to obtain a license and start earning an income before the repayment requirements begin.

There is an element of risk in any loan program. However, we urge the Congress to consider the payoff as well as the risks in the HEAL program. For us in the American Black Chiropractors Association, and our Hispanic, Native American and Asian-American chiropractic colleagues, the payoff has been achievement, success and an opportunity to serve our respective communities as taxpaying citizens and responsible professionals. The payoff has been dignity and the fulfillment that accompanies the practice of an important and meaningful profession.

Please do not shut the door to the HEAL program. It is a program that works.

Mr. KOSTMAYER. Thank you, Doctor, very much. I want to thank all of the witnesses.

We ask the next panel to come forth. We have Mr. Bruce Behringer, MPH, Virginia Primary Care Association; Dr. Edward J. Stemmler, M.D., executive vice president, American Association of Medical Colleges; Dr. Robert Graham, M.D., executive vice president, American Academy of Family Physicians; David Richards, D.O., chairman of the board of the American Association of Colleges of Osteopathic Medicine, accompanied by Andreas Morales, fourth year medical student at the Texas College of Osteopathic Medicine; and Jay A. Gershen, D.D.S., professor and chairman, public health dentistry, school of dentistry, UCLA.

Mr. Behringer, would you like to begin?

STATEMENTS OF BRUCE BEHRINGER, EXECUTIVE DIRECTOR, VIRGINIA PRIMARY CARE ASSOCIATION, ON BEHALF OF NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS AND NATIONAL RURAL HEALTH ASSOCIATION; EDWARD J. STEMMLER, EXECUTIVE VICE PRESIDENT, AMERICAN ASSOCIATION OF MEDICAL COLLEGES; ROBERT R. GRAHAM, EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS, ALSO ON BEHALF OF AMERICAN ACADEMY OF PEDIATRICS, AMBULATORY PEDIATRIC ASSOCIATION, AMERICAN COLLEGE OF PHYSICIANS, SOCIETY OF GENERAL INTERNAL MEDICINE AND ASSOCIATION OF PROFESSORS OF MEDICINE; DAVID M. RICHARDS, CHAIRMAN, BOARD OF GOVERNORS, AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE, ACCOMPANIED BY ANDREAS MORALES, FOURTH YEAR MEDICAL STUDENT, TEXAS COLLEGE OF OSTEOPATHIC MEDICINE; AND JAY A. GERSHEN, PROFESSOR AND CHAIRMAN, PUBLIC HEALTH DENTISTRY, SCHOOL OF DENTISTRY, UNIVERSITY OF CALIFORNIA, LOS ANGELES, AND PRESIDENT, AMERICAN ASSOCIATION OF DENTAL SCHOOLS

Mr. BEHRINGER. Good morning, Mr. Chairman, and members of the subcommittee, my name is Bruce Behringer, and I am the executive director of the Virginia Primary Care Association; however, today, I am here to represent the National Association of Community Health Centers and the National Rural Health Association. Both of these organizations have the common thread of community and migrant health centers as their members, and are working together to enhance the operations of these health centers.

As you know, community and migrant health centers provide basic comprehensive and preventive primary health care to over 6 million of America's most vulnerable people, two-thirds of whom are children and women of child-bearing age. Patients at health centers range from economically disadvantaged residents of rural, isolated, resource-poor community, inner city ghettos, to migrant farm worker labor camps.

Health centers alone have identified a need of up to 2,000 physicians over the next 2 years, representing both staff turnover and increasing needs for primary and preventive care providers.

In the 1930's, 80 percent of doctors were trained for family care. Now, three out of four physicians are specialists, the pyramid of health manpower, primary care manpower is turned upside down from the way it should be.

It will influence in the long run the inability of areas to recruit primary care physicians, not just the isolated rural areas of the country, or the impoverished inner cities, but all areas.

Second, it is going to influence a fewer number of primary care role models who will influence or not, therefore be able to influence more medical students to choose primary care as their profession.

Third, in a very rational move, the behavior of the medical schools, they could in turn become institutions of high technology and research, because that is where the financial incentives are. That is where the consumer interest of those people who are paying tuition to the medical schools lies, also.

Finally, if we don't turn around this problem, it will result in an ever-increasing health care expenditure, not only for the consumer, but for the Federal Government, which is specialty-driven rather than primary care-driven, which is driven by higher technology as opposed to preventive care.

The health manpower issue in rural areas is certainly dangerous right now. Three out of every four physicians in rural areas are primary care physicians, and there simply are not enough providers to be able to be recruited back into the rural areas where the aging physician population is either retiring or passing away.

There are over 2,000 health manpower shortage areas in the country, and over 4,000 physicians are needed to fill these health professional shortage areas.

Community and migrant health centers, just one small portion of these, have identified a need for up to 2,000 primary care physicians over the course of the next 2 years. Therefore, the National Rural Health Association and the National Association of Community Health Centers bring before you a series of recommendations regarding the reauthorization of the title VII and title VIII programs.

We are in support of the reauthorization, and we would like to make the following recommendations:

One, health professions programs should give preferential consideration to qualified applicants from rural areas, underserved communities, and other minorities in the admissions process as a method for increasing the health profession pool in rural and urban areas.

Number two——

Mr. **Waxman**. The rest of that statement will be in the record. Sorry. We have to keep to that 5-minute rule.

[Testimony resumes on p. 110.]

[The prepared statement and attachments of Mr. Behringer follow:]

STATEMENT OF BRUCE BEHRINGER

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Health centers have traditionally depended on the National Health Service Corps to provide primary care physicians. However, the number of physician scholarship awards has decreased from a peak of 5,375 in 1980 to 46 in 1990. With the recent revitalization of the NHSC program, it is anticipated that beginning in 1992, approximately 500 scholarships will be awarded each year. However, because of the time it takes to train medical students, only 50 scholarship physicians will be available each year until 1996. Health centers alone have identified a need of up to 2000 physicians over the next two years representing both staff turnover and increasing needs for primary and preventive care providers. Medically underserved areas must therefore look at other federal programs to provide them with needed health professionals.

Both organizations view the reauthorization of the Title VII and VIII programs as crucial to fulfilling some of the urgent manpower needs in rural and medically underserved communities which have great difficulty in recruiting and retaining providers and would like to make some suggestions for change which would enhance primary health care providers to these communities.

It is clear that the current medical care and medical education systems in the U.S. are not characterized by their strengths in developing primary care physicians or for serving underserved populations. Furthermore, academic prestige for medical school faculty does not come from primary care but rather from a combination of published research, research grants, and fee-for-service income; while primary care medical faculty members have fewer opportunities to apply for and receive federal research grants as the amount of grants for primary care research is extremely small. As an example, in 1989, the National Institutes of Health awarded $5.5 billion in research grants, of which only $15.4 million or 0.27% could be classified as primary care research. In addition, the fee-for-service for primary care procedures have long been recognized as being significantly less than for subspecialists visits and procedures, thus making primary care one of the least attractive field in medicine.

However, recent studies have identified the need for changes in the education and training of physicians from a tertiary-care, hospital-based experience to a primary care, community-based experience. Others have recommended increasing the exposure of students and residents to both community-based primary care and underserved populations. While both rural and urban health centers have identified great needs for health professionals, the level of need for rural health centers is over 30 percent greater than the need in urban health centers.

Currently, there are approximately 600,000 practicing physicians in the U.S. Of these approximately one-fourth or 150,000 are primary care providers. In rural areas, three out of every 4 physicians practice primary care and there are just not enough primary care providers in either rural or urban areas to meet the need for service. There are over 2000 Health Professional Shortage Areas (HPSAs) and over 4000 physicians needed in these HPSAs.

With such an extreme need, and with Titles VII and VIII up for reauthorization the National Rural Health Association and the National Association of Community Health Centers and believe that their recommended changes to these programs could greatly enhance and increase the number of primary care providers to both rural and urban areas and therefore urge you to include the following provisions in the health professions reauthorization:

1. Health professions programs should give preferential consideration to qualified applicants from rural areas, underserved communities, and other minorities in the admissions process as a method for increasing the health professional pool in rural and urban areas.

2. Undergraduate programs should be encouraged to require students to participate in substantive rural-oriented training programs. All colleges of medicine should have strong family medicine and primary care training programs.

3. Federally-supported education and training programs should develop service linkages with rural and other underserved providers to improve health care in underserved areas, including community and migrant health centers.

4. Support should be given to community and migrant health centers and other underserved providers to serve as role models and to actively recruit students in health professions training programs.

5. Providing financial support and incentives for minority and disadvantaged students from rural areas as well as other medically underserved areas to enter a professional health career;

6. Developing and expanding the number of community and migrant health centers that provide graduate medical education for primary care providers.

7. Priority should be given in awarding grants to those institutions that have a good track record in training individuals for primary care practice.

8. Federal funds should be allocated for the establishment of traineeships in community and migrant health centers.

9. Incentives should be given to nursing education programs which offer a rural-based curriculum to prepare health professionals for rural practice, especially in increasing opportunities for career development for rural nurses; cross-training nurses beyond their job descriptions; and by increasing opportunities for nursing students to have training opportunities in rural practices.

10. Nursing schools should have affiliations with community-based home health agencies, community nursing organizations, and nursing homes to better meet the needs of underserved populations.

11. State participation in AHEC funding should be required within three years for all new and existing programs.

12. Health Education and Training (HETC) Center funding should be continued and expanded to include more rural and frontier areas.

13. AHECs and HETCS should be encouraged to participate in community and migrant health centers; work with local health departments; affiliate with primary care residency programs; work with state primary care associations and offices of rural health; create preceptorships, including those in Indian Health Service and contractor sites; and be involved in training of mid-level providers.

14. AHECs and HETCs should be encouraged to participate in demonstration programs in state projects with the NHSC; in telecommunications linkages; and in AIDS education and emerging technology for providers and students.

15. AHECS should be encouraged to participate in minority health programs.

I have submitted for the record, a copy of the recent analysis entitled "Health Professional for Health Centers: The Physician Pipeline to Health Centers" by Dr. Darryl Leong.

Mr. Chairman and members of the Subcommittee, I thank you for the opportunity to testify before you today.

Health Professionals for Health Centers
The Physician Pipeline to Health Centers

Darryl Leong, M.D., M.P.H.

The national network of community and migrant health centers represent a national system of providing access to comprehensive primary care services for millions of medically underserved and poor Americans. In 1990, approximately 2,500 physicians worked in health centers and another 6,700 other health professionals such as nurse practitioners, physician assistants, nutritionists, medical technologists, pharmacists, dentists, etc.

Historically, the National Health Service Corps has served as the mainstay of providing physicians for health centers (currently at its lowest level of 627 (27%) health center physicians). Moreover, the total number of physician scholarship awards has decreased from a peak of 5,375 in 1980 to 46 in 1986 where it has remained through 1990. Even with the revitalization of the NHSC in 1991, only about 500 scholarships will be awarded each year beginning in 1992. And because of the normal lag time for the training of medical students, only 50 scholarship physicians will be available each year until 1996. Only 285 physicians through the NHSC loan repayment program will be available for all health professional shortage areas in the coming year and not all available physicians will be assigned to health centers. Finally, a good portion of the 627 assignees may not stay with their health center after their obligation period ends.

Physician services in health centers are provided by licensed and qualified doctors that come to health centers from a variety of sources (Graph 1) other than the NHSC. An analysis of the other sources of physicians for health centers clearly shows that health centers have to compete for physicians along with private practice, health maintenance organizations, hospitals, group practices, universities, other countries, public health clinics, and others. Furthermore, health centers have been forced to look into the competitive market by the decreasing supply of Corps assignees and by the low retention rates of assignees (~25%). However, many health centers have chosen to recruit in the open market for physicians because they have found higher retention rates when physicians come by their choice[1]. In fact, the number of health center physicians rose from 2100 to 2500 from FFY 1989 to 1990, representing an increase of 400 new physicians.

A Physician Pipeline to Health Centers

A look at the pathways for becoming a physician (Graph 2) from premedical students to post-residency physicians that work in health centers provides another insight into where physicians that work in health centers come from, e.g. *is there a pipeline for students to become physicians at health centers?* Four levels in the pipeline are defined: students before they enter medical school (premedical), medical school, medical residency training, and the practicing physician level. As pointed out above, health centers literally compete for primary care physicians graduating each year.

The concept of a physician pipeline to health centers for physician training is not a new one. The NHSC represents an implementation of this concept, with the exception that physicians are placed in underserved areas as part of their obligation for accepting NHSC scholarships or loan repayments. Programs in the Bureau of Health Profession target financial aid to disadvantaged and minority students to enter health careers, and provide grants to schools of public health, allied health professions, medical schools primary care residency training programs, and centers of excellence for under-represented minorities.

It behooves health centers to seek a complementary strategy with the NHSC, the Bureau of Health Professions, the Office of Minority Health, and other private and public professional and educational groups to affect all four levels of the physician pipeline to health centers. However, as the current medical care and medical education systems are not characterized by its strengths in developing primary care physicians or for serving underserved populations, strong and innovative strategies will be required. This strategy is expected to result in an increases in all four parts of the pipeline, to greatly increase and retain the number of physicians to enter or stay with health center careers as a matter of choice and pride, and to reverse current trends in subspecialty and non-underserved physician practices.

Health Center Health Professional Needs

Where do the data for staffing requirements come from? The major source of data for health professional counting on a national level continues to come from the BCRR health professional FTE reporting system. The number of NHSC assignees comes from the NHSC tracking system. Recently, the 1990 NACHC health center survey[2] provided another source of data for projecting health professional staffing needs for health centers.

The number of physicians in health centers cited at 2500 physicians is based on BCRR data from fiscal year 1990[3]. A year ago, this number was at 2100 physicians and two years ago it was 2500. Since this is BCRR reporting of full time equivalents, the total of 2500 is actually a total of FTEs and not a count of the number of physicians that work in health centers. According to the NHSC, approximately 627 assignees are completing their assignments during fiscal year 1991.

The NACHC Data Book[4] methodology calculates the number of physicians needed by calculating the number of current C/MHC vacancies for NHSC physicians and adding this to the HRSA High Priority Opportunity List and Loan Repayment vacancy estimates. This calculation results in a figure of 930 vacancies expected during the current fiscal year.

The 1990 NACHC survey of health centers included a section on health professional staffing and health professional needs for each of the disciplines commonly found in health centers. 230 of the 544 health centers responded to the survey of which 222 (130 rural, 92 urban) comprised the basis for analysis. Table 1 shows the results of the survey. Since the number of respondents for each of the health professional disciplines varied, the raw totals of actual and needed are normalized for comparative purposes.

The total number of physicians (2,838, Table 1, column 4) at health centers and was calculated by extrapolating the number found in the 230 respondents to the entire 543 (330 rural, 213 urban) health centers[5]. While the total number of physicians in rural health centers of 1,404 is close to the total of 1,434 in urban health centers (Tables 2 and 3), the average number of physicians in rural health centers is much less than the urban health centers (4.25 vs 6.73). The average number of physicians for both types of health centers is 5.26.

Health centers also responded to estimating needs for health professionals over the next year. Using similar methods for adjusting the reported number of physicians at health centers, the total number of physicians needed for all 543 health centers is 2,027 or 70.7% of the current total of all physicians (Table 1, Column 7 and 10) with an average need per health center of 3.72 physicians. The number of physicians needed for rural health centers is 1,136 or 81.0% (Table 2, Column 7 and 10) of current rural health center physicians is greater than the needs for urban health centers, 891 or 62.1% (Table 3, Column 7 and 10) of current urban health center physicians. The level of need for both rural and urban health centers representing over 70% of current physician staffing confirms the high level of current physician needs and that rural health center needs are even more acute.

Family physicians dominate both the current and needed physician totals, 45.0% and 42.1%, respectively for all health centers. Similarly, in rural health centers, family physicians account for 61.9% of all rural health physicians and 55.9% of physician needs. For urban health centers, the numbers for family physicians are 29.3% and 28.3%. This demonstrates the higher needs for family physicians in rural areas, but urban health centers have a need for an increase of over 60% over their current numbers. Moreover, even though family and general practitioners account for 42.1% of physician needs for all health centers, this means that pediatricians, general internists, and obstetrician-gynecologists account for the other 58% of physicians needed.

Pediatricians account for 11.9% of rural health center physician staff, but had the highest need/current ratio of all four physician types of 1.32. Obstetrician/gynecologists needed for urban health centers have a high need/current ratio of 1.24, although rural health centers have a ratio of 0.83 showing high needs as well. Also, internal medicine physicians are the predominant physician type among urban health centers (31.6%). These data underscore the need for all physician types for both urban and rural health centers.

These calculations are repeated for each of the health professional disciplines and show 8,728 other health professionals which gives a ratio of other health professionals to physicians of 3.30, i.e., non-physician health professionals are 3.3 times more prevalent than physicians. The average number of non-physician health professionals per health center is 16.34. For rural health centers, the average is 11.56 vs. 23.07 for urban health centers. In terms of needs, 6,527 other health professionals are needed, representing 75.1% of the current total. While the need for registered nurses, licensed practical nurses, and technologists account for over half of the need in this area, all disciplines have high needs in their own areas with respective need/current proportion ranging from 65%-94% (Table 1, Column 10).

Urban health centers have a higher ratio of non-physician health professionals to physicians of 3.56 vs. the 2.99 ratio for rural health centers. However, rural health centers show a much higher need for other health professionals across the board with an average need/current ratio of 0.89 vs. the 0.65 for urban health centers.

The average number of dentists for all health centers is 1.02, 0.65 for rural health centers, and 1.53 for urban health centers. These averages translate to total number of dentists of 540, 214, and 326 for all, rural, and urban health centers respectively. Needs for dentists are identified at 76% of current totals or approximately 418 dentists.

Health Professionals for the Future

Table 4 is a composite table of physician requirements for the expansions and new starts called for in the NACHC's Access 2000 proposal. The table is constructed by making a number of assumptions: 1) the retention rate for NHSC assignees will increase from 25% to 52% over the next 9 years; 2) 80% of new NHSC assignees will go to health centers; 3) the turnover rate of physicians in health centers will decrease from 37% to 23% over the next 9 years; and the patient to physician ratio of 2400:1 will improve to 1824:1 over the next 9 years. The number of physicians available from the NHSC is projected in Table 5[6], with no large increases in assignees until FFY 1996 and beyond.

With the above assumptions (which are open to variation), the number of additional physicians needed to serve the additional number of patients begins at 515 in FFY 92 and rises to a peak of 1,877 in 1997 and decreases to 384 in the FFY 2000 (line 10). The National Health Service Corps contribution to these numbers starts at a low of 288 physicians in FFY 92 (55.9%) and rises to a high of 648 (168.8%) in FFY 2000. The non-NHSC physician requirement is the difference between the total need and the NHSC contribution (line 12), which is 227 (44.1%) in FFY 1992, dropping to a low of -68.8% in FFY 2000.

The cumulative number of additional physicians required is found on Table 4, lines 13 to 17. Of the cumulative total of 10,237 additional physicians required over the 9-year period, 5,897 (57.6%) is projected to come from new NHSC assignees and 9,607 (68.7%) will come from non-NHSC sources. Another way of looking at the real physician needs is obtained by adding in the "normal" or expected physician turnover which adds another 1,476 physicians in FFY 92 for a total of 1,991 physicians needed in the first year of Access 2000 with a cumulative total of 38,255 at the end of FFY 2000.

The number of other health professionals required is projected by using the ratio of other disciplines needed to physicians needed (ratio = 3.30) which was obtained from the 1990 survey (see Table XX). For all non-physician health professionals, the total needed for FFY 92 is 1,700. This number is broken down in the table for each of the most common health professionals employed by health centers. The cumulative total for other health professionals is 33,785. Registered nurses led the other health professionals in projections for FFY 92 with 337 needed, followed by LPNs (278), medical and radiologic technologists (262), community workers (132), nurse practitioners (115), dentists (107), social workers (106), and others.

Recent Publications

A number of recent publications provide excellent current descriptions of the status and trends in health professional supply for the underserved: the latest in a series of reports on the status of health personnel in the U.S. published by the Bureau of Health Professions[7]; a report on rural health care which included a chapter on rural health personnel needs[8] published by the Office of Technology; the AAMC Data Book of statistical information related to medical education[9]; a report of a study of primary care physicians graduate medical education published by the Institute of Medicine[10]; the proceedings[11] from the HRSA 1990 conference entitled "Education of Physicians to Improve Access to Care for the Underserved"; and New England Journal of Medicine article and "Constraining the Supply of Physicians: Effects on Black Physicians" by Hanft and White[12].

Physician Surplus or Shortage?

There has been disagreement about the supply and requirements for physicians for the year 2000 and beyond. The projections range from a large surplus of primary care physicians to a deficit of primary care physicians. Even the size of the surplus is not agreed upon with the Bureau of Health Professions projections showing greater needs for primary care physicians than the Graduate Medical Education National Advisory Committee[13] (GMENAC) and the American Medical Association[14]. The BHPr projects less physicians available with about 25,000 less physicians in 1990 and 66,000 physicians less in 2000 than the latter two sources. The Council on Graduate Medical Education (COGME) agreed with the projected oversupply of physicians but noted the undersupply in family practice, general internal medicine[15].

The key factor accounting for the various difference lies in the assumptions made in defining physician needs. In particular the per capita utilization rates for ambulatory and hospital care weigh in heavily. These factors and others provided the basis for the article "Why There will be Little or No Physician Surplus between Now and the Year 2000" by Schwartz, Sloan, and Mendelson[16]; The Bureau of Health Professions summarizes its current view of the future adequacy of physician supply as follows:

> "The BHPr estimates for physicians in 2000 are less than its supply projections. However, it should be emphasized that supply/requirements comparisons in the assessment of supply adequacy should be interpreted cautiously before being considered as justification for private or policy changes. Reasonable alternative assumptions can produce markedly different conclusions about adequacy of supply. Most importantly, the expectation that

> the number of physicians available should be equal to the number of physicians needed should be reassessed."

This is in light of projections for the supply of primary care physicians as follows. In 1987, there were 585,597 physicians practicing in the United States of which 151,651 (24.6%) were in general practice and the three major primary care fields of family practice, general internal medicine, and general pediatrics (Graphs 4 and 5). There were approximately 2100 physicians (1.4% of total primary care physicians) working in community and migrant health centers in 1987. The ratio of approximately 3 subspecialists for every primary care physicians is projected to not change significantly through the year 2020 . In fact, the disparity is expected to worsen slightly (Graph 6).

Adding to the concern over the adequacy of primary care physicians are recent trends in match rates for primary care residencies and choice of specialties by senior medical students in the U.S. From 1986 to 1989, residency program match rates for the three major primary care specialties (family practice, general internal medicine, and pediatrics) decreased by 12.6%, 8.1%, and 15.6% respectively (Graph 7). Furthermore, there has been a decrease in the percentage of medical students intending to enter a primary care career from 38.8% in 1981 to 25.4% in 1989, with the largest drop coming from general internal medicine (Graphs 8 and 9).

Academic Prestige of Primary Care

Various reasons have been cited for the decreasing lack of interest in primary care including higher medical student debts, lack of progress in increasing the number of minority medical students and physicians, lack of minority and female representation on medical school faculty, lack of strong primary care role models for medical students, absent or weak departments of family and community medicine, lack of required medical student rotations in primary care, inaccurate depiction of primary care from hospital outpatient experience, and lower potential income for primary care practitioners.

However, one viewpoint holds that academic prestige for medical school faculty comes from a combination published research, research grants, and fee-for-service income. In fact, fee-for-service income and research grants comprised over 57% of medical school revenues in 1987 with only 5% of the revenue coming from tuition and fees (Graphs 10 and 11).

Primary care medical faculty members clearly have much fewer opportunities to apply for and receive federal research grants as the amount of grants for primary care research is extremely small. In 1989, the National Institutes of Health awarded $5.5 billion in research grants, of which $15.4 million (0.27%) could be classified as primary care research[17]. Adding in all other known sources of federal research dollars for primary care yields a total of $36.7 million. Moreover, none of the current institutes has primary care or community health or prevention as its primary focus.

Fees generated by primary care visits and procedures have long been recognized as being significantly less than for subspecialists visits and procedures. This has resulted in a new Medicare fee system labeled the resource-based relative value scale which should significantly increase fees for primary care providers. However, even with implementing all of RB/RVS, it is likely that the gross disparity between average income in subspecialists and primary care physicians will continue.

The support from research grants and medical service fees allows not only the development and testing of hypotheses, but also the support needed to submit articles for publication in medical and health journals. And a track record of publications is critical to further research support, tenure, and other support within an institution.

Put another way, the academic prestige of primary care will not change significantly without large increases in research dollars for primary care and the concomitant value that it adds to primary care medical faculty. Intellectually, research questions in primary care and health services delivery are equally valid to biomedical research questions. It is time that these questions get addressed and the results published and disseminated.

Training Primary Care Physicians for the Underserved

Some of the alarming trends in the decrease of students and residents interested in primary care has already been pointed out above. In 1989, the Institute of Medicine[18] published a report of a study by a committee charged to develop strategies to overcome barriers to financing graduate medical education for primary care practitioners in ambulatory settings. The committee was chaired by Daniel Federman, then Dean of the Harvard Medical School and concluded that care provided by future generations of primary care physicians would be enhanced if the GME experience placed greater emphasis on training in primary care outpatient settings.

David Greer of the Brown University Program in Medicine, in a paper commissioned[19] for the 1990 conference entitled "Education of Physicians to Improve Access to Care of the Underserved" clearly documents the role of academic medical centers in serving societal needs for primary care practitioners and makes a number of provocative recommendations for change that he acknowledges will be controversial. Jack Colwill of the University of Missouri reviewed history and current status of barriers to linkages between education and the delivery of primary care and suggested that a critical step is the commitment and the agreement among medical school faculty of the Nation's need for primary care physicians in general and to the underserved as well[20]. John Noble of the Boston University School of Medicine, at the same conference reported on his collaborative studies with Barbara Starfield and Robert Friedman which found that graduates of federally funded primary care programs were more likely to choose primary care careers and to practice in areas with lower physician-to-population programs[21].

Role of Community and Migrant Health Centers in Medical Education and in the Retention of Physicians

Recently, a survey of all federally-supported graduate medical education programs and community and migrant health centers found 39 health centers that have a block or longitudinal experience of medical residents at the health center. 24 of the 39 reported a longitudinal experience. Since there are about 500 health centers, 24 is a very small number. Centers such as the Montefiore Family Medicine Program and the Brown University Family Practice Program have reported a high proportion of graduates going on the community or migrant health center practices and feel strongly that the training experience plays a strong role in career choices.

These 24 health centers and their medical education colleagues have obviously overcome significant barriers to developing a residency training program in the past and current environment for funding graduate medical education and the fact that health centers are regulated as service providers and not as training sites. Assuming an average of 4-6 residents per health center means that about 120 residents per year are coming into practice with a community health center experience.

At a recent conference on health professionals for Access 2000, a NACHC workgroup clearly identified the need for health centers to be involved in the education and training of physicians and other health providers. They strongly supported health center activities at all four levels of the theoretical physician pipeline to health centers. These strategies are summarized in the following tables which are organized to show the four levels of intervention in this strategy, suggested achievement goals for each level, possible activities and strategies, and their relationship to current federal and national programs.

Level of Intervention	Current Programs
1. **Pre-Medical School Level.** An increase in the number of students destined for community health center practice ("A" in Graph 2) by:	
a. Developing and promoting community-based education programs that encourage and directly assist students in the community to enter primary health care careers, e.g. develop an "office of education" at all or selected community health centers.	
b. Developing and promoting opportunities for student employment and exposure to community and migrant health center work;	Office of Minority Health, BHPr
c. Supporting and promoting minority education assistance programs.	NHSC Field Services
d. Supporting and promoting the NHSC scholarship program.	
2. **Medical School Level.** Increase in the number of students in medical school level that enter a primary care residency ("B" in Graph 2) and in particular, *increase the number of students entering a community-based primary care residency training program by:*	
a. Increasing the academic prestige of primary care and community health;	BHPr, ?
b. Increasing the number of students and faculty who are aware of community and migrant health centers as a career choice;	NHSC Field Services (Advocacy Network, AMSA, COSTEP)
c. Increasing student and faculty awareness of public health programs that provide assistance to students interested in community health.	NHSC, PHS, NACHC Clinical Affairs
d. *The expansion of primary care and community health research to a level that sufficient to increase academic prestige of primary care and departments of community medicine.*	Agency for Health Care Policy & Research, NIH
e. Increasing the number of departments of community health or family medicine and establishing required rotations in community medicine;	AAMC, BHPr
f. Increasing the number of academic publications that study or refer to community and migrant health centers.	All

3. **Medical Residency Level.** Increase in the number of graduating residency physicians who choose primary care and health centers as a career choice by:	Current Programs
a. Increasing the number of primary care residency programs that have a strong link with community or migrant health centers;	Bureau of Health Professions
b. Expanding and developing primary care residency training programs based at health centers.	BHPr Medicare/Medicaid
c. Developing financing mechanisms for supporting training programs at health centers.	Medicare/Medicaid
d. Increasing the number of residents and faculty who are aware of community and migrant health centers as a career choice;	BHCDA
e. Establishing ongoing dialogue and information exchange with national training organizations and federally-funded training programs.	NACHC, S/RPCA

4. **Medical Practice Level.**	
a. Increase in the number of practicing clinicians who choose health center careers either for the first time or choose to return to a health center by:	
i. Increasing the visibility of community and migrant health centers as a career choice for practicing clinicians, professional organizations, institutions of higher education, hospitals, and other health facilities.	NACHC, S/RPCA
ii. Establishing national, state, and local marketing programs.	NACHC, S/RPCA, C/MHC
iii. Expanding and developing state/regional primary care association and individual community and migrant health center recruitment and retention programs.	
iv. Coordinating with other recruitment and retention efforts.	NACHC, S/RPCA, C/MHC
v. Supporting and promoting NHSC loan repayment programs;	NHSC
b. Increase in the number of health center clinicians who choose to remain in the health center system, e.g. decrease the turnover ratio of clinicians in health centers by:	
i. Supporting and promoting NHSC loan repayment programs;	NHSC
ii. Developing standardized benefit packages;	NACHC, S/RPCA, C/MHC
iii. Developing clinical director orientation and training programs;	NACHC/NPCI
iv. Developing career tracks for clinical directors;	NACHC, BHCDA
v. Supporting research on important factors in clinician retention;	AHCPR, BHCDA
vi. Expanding and promoting clinician incentive programs;	NACHC, S/PRCA, C/MHC
vii. Developing and promoting clinician involvement in national affairs;	NACHC, S/PRCA, C/MHC
viii. Developing and supporting clinical networking;	NACHC, S/PRCA, C/MHC
ix. Developing and supporting clinician recognition;	NACHC, S/PRCA, C/MHC

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2. "A Snapshot View of Community Health Centers after 25 Years", National Association of Community Health Centers, Lewin/ICF, January, 1991.

3. Unpublished data. Bureau of Health Care Delivery and Assistance.

4. National Association of Community Health Centers, "Data Book 1991", February, 1991.

5. The variance of the projected total number of physicians of 2838 is attributed to the different methods used and the possibility that the 222 health centers are not totally representative of all health centers.

6. These number are tentative pending a formal report from the NHSC.

7. "Seventh Report to the President and Congress on the Status of Health Personnel in the United States", Bureau of Health Professions, DHHS Publication No. HRS-P-OD-90-1, March 1990.

8. "Health Care in Rural America", Office of Technology Assessment, U.S. Congress, OTA-H-434, Washington, D.C., September, 1990.

9. "AAMC Data Book", P. Jolly and D. Hudley, Association of American Medical Colleges, May 1990.

10. "Primary Care Physicians: Financing Their GME in Ambulatory Settings", Division of Health Care Services, Institute of Medicine, National Academy Press, Washington, DC, 1989.

11. Health Resources and Services Administration, Proceedings, "Education of Physicians to Improve Access to Care for the Underserved", DHHS, PHS, March 21-23, 1990.

12. Hanft, R.S. and White, C.C., "Constraining the Supply of Physicians: Effects on Black Physicians", Milbank Quarterly, 65(Supp 2):249-269, 1987.

13. U.S. Department of Health and Human Services, "Report of the Graduate Medical Education National Advisory Committee to the Secretary, Department of Health and Human Services, vol. I: Summary Report", DHHS Pub. No. (HRA) 81-651. U.S. Government Printing Office, Washington, D.C., 1981.

14. American Medical Association, Center for Health Policy Research, "Physician Supply and Utilization by Specialty: Trends and Projections", Chicago, 1988.

15. U.S. Department of Health and Human Services, "Council on Graduate Medical

Education: First Report of the Council, Volumes I and II", U.S. Government Printing Office, July, 1988.

16. Schwartz, W.B., Sloan, F.A. and Mendelson, D.N. "Why There will be Little or No Physician Surplus between Now and the Year 2000", New England Journal of Medicine, 318(14):892-897, April 7, 1988.

17. Mullan, Fitzhugh, "The Federal Investment in Primary Care Research", Proceedings, Education of Physicians to Improve Access to Care for the Underserved, March 21-23 1990, p. 469.

18. Institute of Medicine, "Primary Care Physicians: Financing Their Graduate Medical Education in Ambulatory Settings", National Academy Press, 1989.

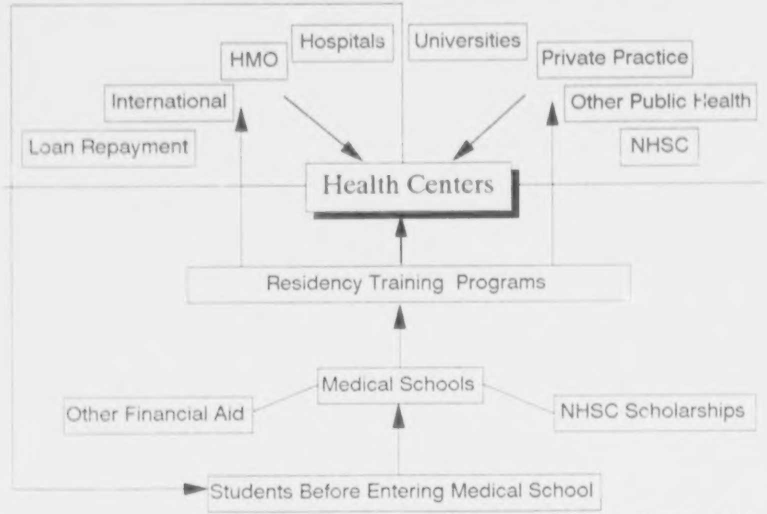
19. Same as number 11. Page 204.

20. Same as number 11, page 319.

21. See number 11. Page 473

Graph 1

Physician Pathways to Health Centers

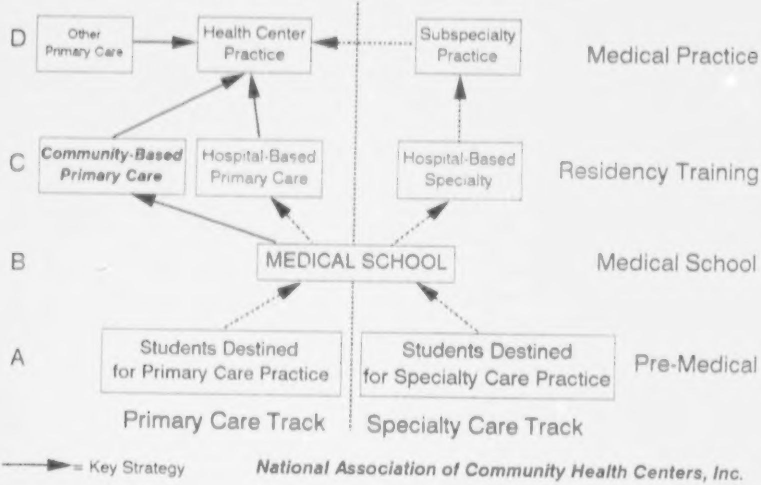

Hospitals
Universities
HMO
Private Practice
International
Other Public Health
Loan Repayment
NHSC
Health Centers
Residency Training Programs
Medical Schools
Other Financial Aid
NHSC Scholarships
Students Before Entering Medical School

National Association of Community Health CenterS, 1991

Graph 2

Physician Pathways to Health Centers

Creating and Maintaining the Pipeline


D
Other Primary Care
Health Center Practice
Subspecialty Practice
Medical Practice
C
Community-Based Primary Care
Hospital-Based Primary Care
Hospital-Based Specialty
Residency Training
B
MEDICAL SCHOOL
Medical School
A
Students Destined for Primary Care Practice
Students Destined for Specialty Care Practice
Pre-Medical
Primary Care Track
Specialty Care Track
= Key Strategy

National Association of Community Health Centers, Inc.

Graph 3

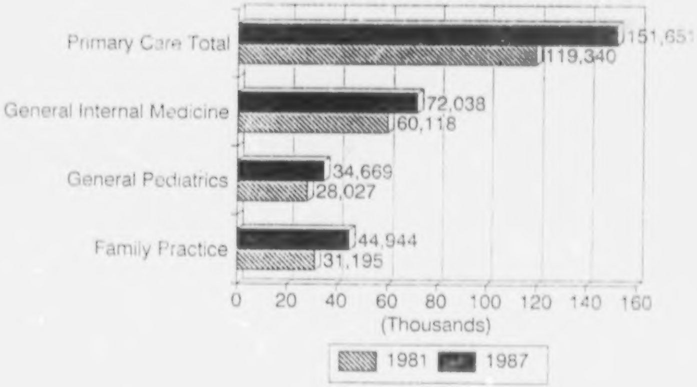
Physician Movement Equilibrium
1990 - 2000

Health Center Practices
Training Programs & Non-Health Center Practices

Access 2000 *National Association of Community Health Centers, Inc.*

Active Physicians in Primary Care

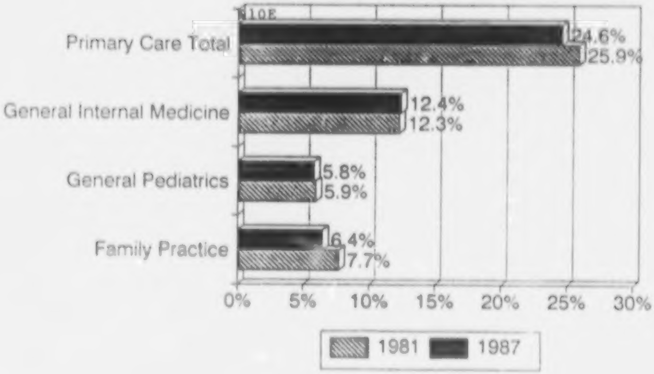
1981 vs. 1987



Source: AAMC Data Book, 1990

National Association of Community Health Centers, Inc.

Active Physicians in Primary Care
1981 vs. 1987, % of All Physicians



Source: AAMC Data Book, 1990

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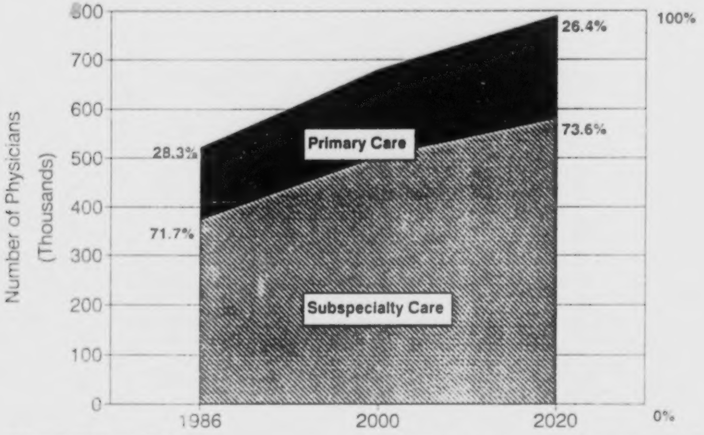
Primary and Non-Primary Care Physicians

1986, 2000, 2020

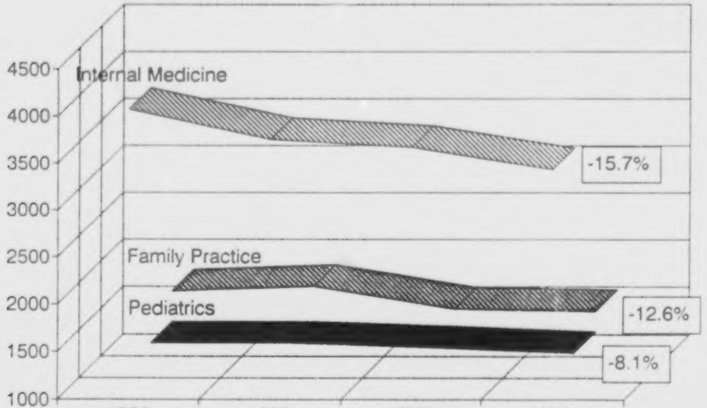


Source: Bureau of Health Professions

National Association of Community Health Centers, Inc.

National Resident Matching Program

Positions Matched by U.S. Seniors

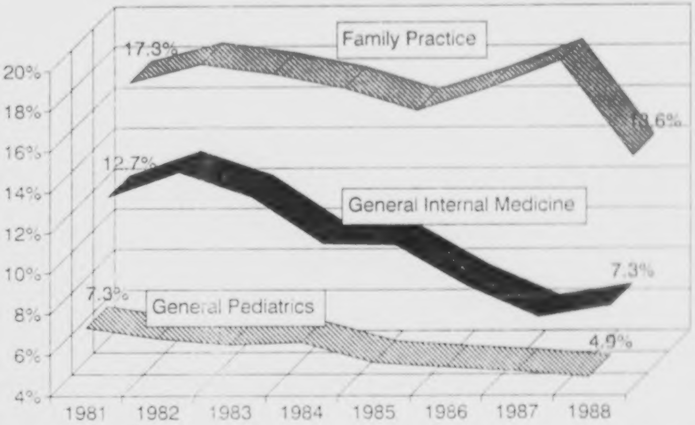


Source: AAMC Data Book, 1990

National Association of Community Health Centers, Inc.

Specialty Choice of Medical Graduates

Percent of All Graduates with Definite Choice

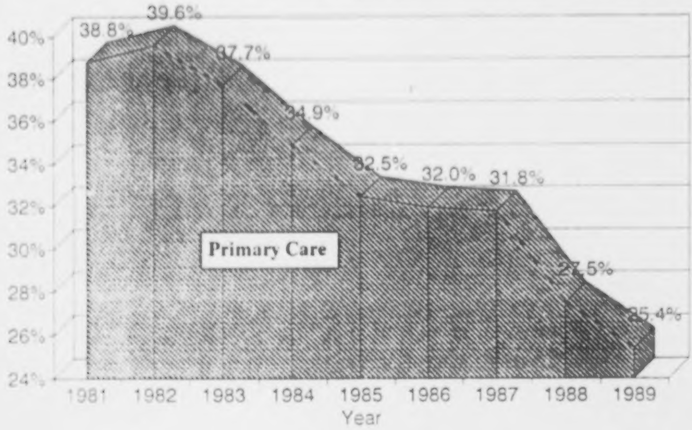


Source: AAMC Data Book 1990

National Association of Community Health Centers, Inc.

Choice of Primary Care

Graduating Medical Students, 1981-89

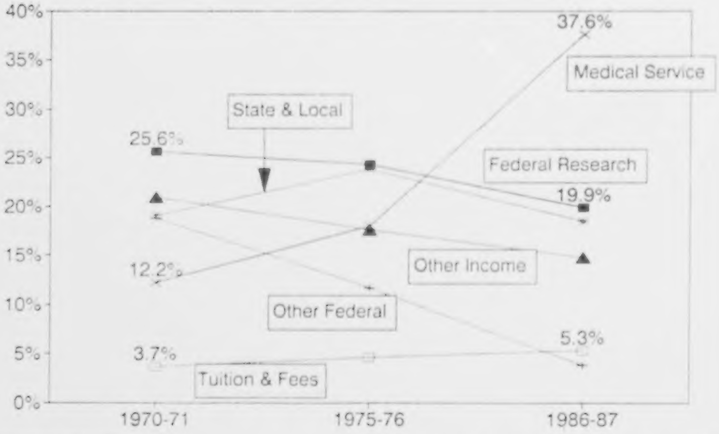


Source: AAMC

National Association of Community Health Centers, Inc.

Trends in U.S. Medical School Revenues

Revenue Sources, Percent of Total

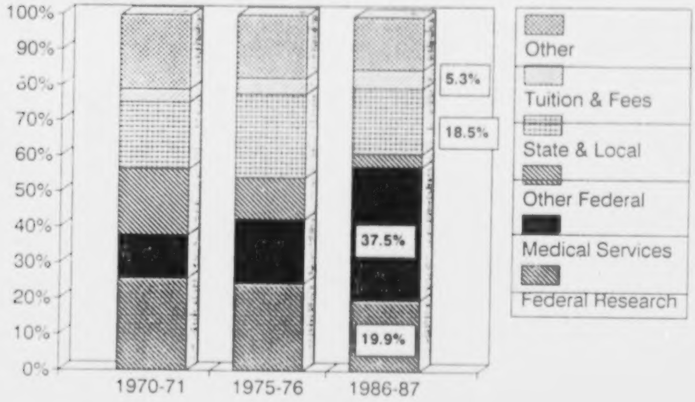


Source: AAMC Data Book, 1990

National Association of Community Health Centers, Inc.

Trends in U.S. Medical School Revenues

Revenue Sources, Percent of Total



Source: AAMC Data Book, 1990

National Association of Community Health Centers, Inc.

Mr. **Waxman**. Thank you very much for your testimony.

I am going to, unfortunately, have to miss the oral presentation of this panel and subsequent panels to follow, although we plan to finish this panel and break until 2 o'clock.

I ask Congressman Kostmayer to take over the Chair and complete the testimony. I have to, unfortunately, catch a flight. I will have a chance to review the record, and look forward to working with all the witnesses as well, on this legislation.

Dr. Stemmler.

STATEMENT OF EDWARD J. STEMMLER

Mr. **Stemmler**. Thank you, Mr. Chairman. And prior to your departure, let us express our gratitude for your leadership in conducting the hearing and your interest in the subject we are discussing.

Mr. Kostmayer, good morning, my name is Edward Stemmler, M.D. I am the executive vice president for the Association of American Medical Colleges, AAMC. The AAMC serves as the national voice for our Nation's 126 accredited medical schools, 420 teaching hospitals, including 60,000 students and 68,000 residents.

On behalf of the AAMC, I appreciate the opportunity to testify on the reauthorization of title VII of the Public Health Service Act and the national supply of primary care physicians.

The AAMC advocates full reauthorization of the title VII programs to support primary care training. We share the subcommittee's concern about the declining number of primary care physicians. Over the past 5 years, the number of graduates planning certification in primary care has decreased from 30 to 23 percent.

National Resident Matching Program data shows that in 1990, only 56 percent of the available family practice and general pediatrics residency positions, and 61.5 percent of internal medicine residency positions were filled by graduates of U.S. medical schools.

Approximately 300 each of general internists and general pediatricians graduate annually from primary care track residency programs, not enough to meet the national need. As medical schools and teaching hospitals seek to increase their commitment to primary care education, model programs, as supported by title VII grants, will be looked to for guidance in planning new approaches.

The title VII primary care grant programs provide valuable and necessary funds for the development and continued existence of primary care educational programs.

Medical schools jointly and individually are complex organizations with a variety of missions. This diversity has served our Nation well. In some areas, such as primary care, special emphasis is necessary.

In these cases, the AAMC believes that incentives provide the best impetus for change and that model programs are an effective method of demonstrating successful implementation of new ideas. An institution can be committed to dual missions that are not mutually exclusive.

In other words, a school may adopt primary care and also be an outstanding research institution. The University of Washington is an example. Public policies should encourage programs that work together. The AAMC views the title VII model programs as a key element in such an equation.

We should continue to fund creative opportunities that expose students to positive experiences. At the individual level, matters of lifestyle and financial reward affect specialty choice. The rising cost of medical education and student debt are often cited as reasons for the decline in selecting lower paying primary care specialties.

While there are many anecdotes that support this hypothesis, the data does not. For your information, I have provided a table that lists the average debt level of medical school graduates by specialty choice. You will note that, surprisingly, there is no clear relationship between debt level and specialty choice.

Data collected annually through the AAMC Graduation Questionnaire indicate that clerkship experiences, mentors, intellectual challenge, and type of patient encountered are the most influential factors in a graduate's specialty choice. For primary care, "lifestyle" factors such as the time demands of the practice conditions are a disincentive to selecting that type of practice.

Another hypothesis to explain the decrease in the number of physicians choosing a primary care specialty relates to the changing nature of the teaching hospital environment and the payment system. Physicians in hospitals are seeing patients who have more complex needs and shorter hospital stays. This creates an inappropriate educational setting.

With diagnostic activities taking place before admission to the hospital, students and residents lose the ability to participate in the diagnostic process.

To ameliorate the distortion that an inpatient experience has on education, there has been an effort to increase the opportunities for clinical education in ambulatory settings. Creating such alternative sites for education is complicated and expensive.

Several studies demonstrate an association between exposure to community-based education and subsequent practice in similar settings. 1989 AAMC data show that of the 12 medical schools with at least 30 percent of their graduates choosing primary care, 10 schools had developed education programs outside the conventional tertiary care teaching hospital.

For example, medical students at the State University of New York in Syracuse who opt for a 1-year primary care clerkship at the school's Binghampton campus select family practice residencies at twice the rate of their peers who remain at the Syracuse teaching hospitals.

Similarly, 61 percent of the graduates of the University of Minnesota Rural Physician Associate Program go into a primary care practice. While there may be a certain amount of self-selection in the outcomes presented, such experiences are available across the country because of the availability of Federal support.

Revenue generated from ambulatory care is insufficient to support such training programs. Without supplemental support, some facilities would be unable to offer educational activities. As a result, fewer students could participate in clerkship experiences that encourage graduates to enter primary care.

Termination of these programs would also affect teaching of cost-effective, preventive medicine. Ambulatory programs train students and residents to manage care, to avoid hospitalization, to counsel patients on strategies for maintaining good health, and to deliver community-based and home care services. Decreased Federal support programs will deny young physicians valuable onsite training.

Providing opportunities for students to observe and participate in model primary care programs is only part of an effective solution to encourage physicians to elect this career. Positive institutional settings must be combined with incentives directed at the individual. This approach has been successfully demonstrated by programs such as Area Health Education Centers, AHEC's, and the National Health Service Corps.

With that, I will end my testimony in strong support of renewal, arguing these programs are just essential as we develop a comprehensive plan to deal with this very vexing problem.

[Testimony resumes on p. 124.]

[The prepared statement of Mr. Stemmler follows:]

STATEMENT OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Good morning, my name is Edward Stemmler, M.D. I am the Executive Vice-President for the Association of American Medical Colleges (AAMC). The AAMC serves as the national voice for our nation's 126 medical schools, 420 teaching hospitals, and 90 academic and professional societies whose members seek to promote public health by providing leadership on policies to educate our 60,000 medical students, to train the 68,000 residents in graduate medical education programs, to develop advances in medical knowledge and to improve the delivery of health care. On behalf of the AAMC, I appreciate the opportunity to testify before the House Subcommittee on Health and the Environment concerning reauthorization of Title VII of the Public Health Service Act and the national supply of primary care physicians.

The AAMC strongly believes the Title VII programs to support primary care training and education should receive full reauthorization. We share the Subcommittee's interest and concern about the declining number of primary care physicians. Over the past five years, the number of graduates planning to be certified in primary care specialties has decreased from 30 to 23 percent. Moreover, 1990 National Resident Matching Program data indicates that only 55.7 percent of the available family practice residency positions were filled by graduates of U.S. medical schools. In general pediatrics, 55.6 percent of the available positions were filled by graduates from U.S. medical schools, and for general internal medicine the rate was 61.5 percent. Approximately 300 each of general internists and general pediatricians graduate annually from primary care track residency training programs. As more medical schools and teaching hospitals seek to increase their commitment to primary care education, model programs, as supported by Title VII grants, will be looked to for guidance in planning new educational approaches nationwide. The Title VII primary care grant programs are a valuable and necessary source of funding for the development and continued existence of primary care educational programs for many medical schools and teaching hospitals.

Since the enactment of the Health Professions Education Assistance Act in 1963, federal health manpower assistance policy has shifted its original emphasis of increasing, in the aggregate, the national supply of health manpower to improving the geographic and specialty distribution of health care professionals. Overall supply considerations have now been replaced with a special focus on the absence of primary care physicians particularly in many rural and inner-city areas. Whether our policies continue to focus on geography or specialty choice, it is clear that an enhanced Federal commitment to Title VII programs is crucial to continue support of primary care training toward the goal of improving the nation's health.

Medical schools jointly and individually are complex organizations with a variety of missions. This diversity has served our nation well. In some areas, however, such as primary care, special emphasis may be necessary. In these cases, the AAMC believes that incentives provide the most effective impetus for change and that model programs are a cost effective method of demonstrating how new ideas can be implemented successfully. The mission of the medical schools, while they vary, also directly contribute to the number of primary care physicians trained each year. It is important to note that an institution can be committed to dual missions that are not mutually exclusive. In other words, a school may take seriously a primary care mission and also be an outstanding research institution. The University of Washington is an example. Federal and state policies should encourage a diversity of programs that work together. The AAMC views the Title VII model programs as a key element in such an equation.

As a group and as individuals, medical students' career decisions are influenced by many factors. For example, schools may emphasize selection of students or try to provide students with clinical education in settings where the role of the primary care physician is optimally demonstrated.

Studies show that positive experiences with a mentor and in a clerkship are the most influential factors in students selecting a career in primary care. Institutions and individuals both need to be understood in this complex issue. At the institutional level, we should continue to provide funds to support creative opportunities for exposure to positive experiences. At the student level, matters of lifestyle and financial reward affect specialty choice.

The rising cost of medical education and student debt are often cited as reasons for the decline in selecting lower-paying primary care specialties. While there are many anecdotes that support this simplistic hypothesis, the data do not. For the Subcommittee's information, I have attached to my testimony a table that lists the average debt level of medical school graduates by specialty choice. You will note that there is no clear relationship between debt level and specialty choice.

Notwithstanding the debate of financial matters, data collected annually through the AAMC Graduation Questionnaire indicate that clerkship experiences, mentors, intellectual challenge, and type of patient encountered are the most influential factors in a graduate's choice of specialty. For the primary care specialties, "lifestyle" factors such as the time demands of the practice environment serve as a disincentive to selecting that type of practice.

Another hypothesis on why we have experienced a decrease in the number of physicians becoming certified in a primary care specialty relates to the changing nature of the teaching hospital environment and the payment system. I am sure you have heard that physicians in hospitals are seeing patients who have more complex needs and shorter hospital stays. This creates an inappropriate environment for medical student and resident education. With diagnostic activities taking place before admission to the hospital, students are losing the ability to participate in that process. The ability to observe the patient over time is limited. To ameliorate the educational distortion that an inpatient experience has had on students' education, there has been an effort to increase the opportunities for clinical education in ambulatory settings. Creating such alternative sites for education is both complicated and expensive.

Several studies demonstrate an association between exposure to community-based education and subsequent practice in similar settings. Students who take elective primary care preceptorships or clerkships are more likely to select a career in family practice and to practice in rural settings. For example, medical students at the State University of New York in Syracuse who opt for a one-year primary care clerkship at the school's Binghamton campus select family practice residencies at twice the frequency of their peers whose clinical education is confined to the Syracuse teaching hospitals. While there may be a certain amount of self-selection in the outcomes presented here, it should be noted that such experiences are available across the country because of the availability of federal support.

Data from the 1989 AAMC Graduation Questionnaire show that of the 12 medical schools that had thirty percent or more of their graduates planning to be certified in family practice, general internal medicine, or general pediatrics, 10 of the schools had developed clinical education programs outside the conventional, tertiary care teaching hospital. Examples include the University of Washington's Washington/Alaska/Montana/Idaho (WAMI) program which has a rural focus. WAMI graduates have an increased likelihood of entering primary care and practicing in rural settings. Similarly, approximately 61 percent of the graduates of the University of Minnesota Rural Physician Associate Program go into a primary care practice.

While the type of experiences I just described increase the chances of students selecting primary care, a study conducted by the AAMC in 1987-88 entitled "Study and Comparisons of Transition of Medical Education Programs from Hospital Inpatient to Ambulatory Training Programs," found that developing the ambulatory setting also increases the costs of medical education and decreases the productivity of a previously non-teaching clinic. The study showed that shifting from hospital-based settings to clinic-based settings for both resident and medical student education invariably decreases the clinic's productivity, particularly in the area of primary care services. Associated costs derive from factors such as supervision, classroom space, and extended time for patient contact, including taking a patient's history. Each of the schools and hospitals that were studied had adapted its ambulatory education programs to opportunities unique to their communities. In some cases, a school was able to affiliate with an existing ambulatory setting, while in other cases, an appropriate training site needed to be developed. While there is a need for more opportunities for students' education in ambulatory settings, resources for accomplishing the shift from hospital to clinic-based sites are scarce. The AAMC has conducted a variety of other activities to address the issue of primary care which support this same conclusion, including an invitational symposium, "Adapting Clinical Education to New Forms and Sites of Health Care Delivery" and publishing the results of a 1988 conference on ambulatory care and education, sponsored in conjunction with the U.S. Department of Veterans Affairs. More recently, the Robert Wood Johnson Foundation awarded the AAMC a one-year grant of $45,000 for a study of influences on the selection of internal medicine as a career. Myself and AAMC scholar-in-residence Joseph Johnson, M.D. will analyze three broad categories which include the characteristics of students, the medical school experience, and students' perceptions about internal medicine practice.

Within the current reimbursement system, the revenue generated from ambulatory patient care is insufficient to support such training programs. Without supplemental grant support, some ambulatory care facilities would be unable to offer educational activities. Inadequate funding of Title VII programs would be most disruptive to training opportunities in the ambulatory care setting. As a result, fewer students may be offered exposure to environments that foster positive clerkship experiences and encourage graduates to enter primary care. Termination of these programs would also affect teaching of cost-effective, preventive medicine curricula. Residents in ambulatory programs are trained to manage care in an effort to avoid hospitalization and to counsel patients on strategies for maintaining good health. Primary care programs train residents in community-based and home-care services. Decreased federal support for these programs will deny young physicians valuable on-site training.

Federal funds have been crucial in the development of many family medicine departments and family medicine residency and training programs. In the 1980's, federal funding partially supported about 40 percent of the family practice programs which train about 50 percent of the graduates. Currently there are 97 medical school departments of family medicine providing ambulatory based training to prepare residents and medical students for ambulatory based practice to encourage residency graduates to practice in rural and other underserved areas. The family medicine departments, as a result of the nature of their training facilities, are often faced with difficult financial constraints. Over two-thirds of the residency programs are located in community hospitals, rather than in traditional tertiary medical centers. In addition to the community hospitals, family practice residency programs are affiliated with community health centers, migrant health centers and free clinics. Location in non-traditional training sites, coupled with an ambulatory based training model provide the residency programs and departments with significant financial challenges.

Patient revenues have not been able to support primary care residency training programs partially because payment for service and education in the ambulatory setting is not at the same level and scope as it is for the hospital inpatient setting. As a consequence, primary care residency programs depend more heavily on federal support. Due to the emphasis on ambulatory and preventive care, reimbursement from Medicare and other third party payers is less than for inpatient, procedurally oriented care. Patient care revenues have been unable to support the training programs. As a result, primary care programs are unable to become "self-sufficient" from patient care revenues. Continued and enhanced targeted federal support is essential for primary care programs.

In addition to the renewed funding for the primary care grant programs, funding should also be continued for the Area Health Education Centers (AHEC) and the Health Education Training Center (HETC) programs that relate academic medical centers to medically underserved rural and urban areas. Currently 38 AHEC programs exist nationwide, constituting a national resource for dissemination of federal priorities and new technologies to practitioners in clinical settings. The AHEC program has been successful in linking the resources of university health science centers with the health care and educational needs of the communities. Many AHECs serve as training sites for medical students and communicate to participants the professional satisfaction of practicing primary care and doing so in medically underserved areas. This comprehensive approach to training ensures an effective partnership between academic health science centers and surrounding communities.

Providing opportunities for students to observe and participate in model primary care training programs is only part of an effective solution to encouraging physicians to elect this career choice. Positive institutional settings must be combined with incentives directed at the individual. This approach has been successfully demonstrated by programs such as the National Health Service Corps. In closing, I wish to indicate strong support for loan forgiveness programs and Title VII programs that provide students with funds to finance their education, particularly the programs that allow student to minimize debt. Low-costs loans such as HPSL and the newly-created disadvantaged loan and scholarship maximize a graduate's flexibility in career decisions by minimizing debt. In the context of career choice, I cannot over-emphasize the importance of directing financial incentives to the individual through means such as the NHSC and subsidized loans. I encourage the Subcommittee to consider the combined role of these programs and the grants for model programs as effective tools to achieve an appropriate balance in the supply and practice location of physicians in the United States.

Indebtedness of 1990 Medical School Graduates
by
Specialty Certification Plans

Specialty Certification Choice	Number	Mean Debt	Percent with No Debt	Percent with Debt ≥ $50,000
Anesthesiology	759	$48,776	17.2	34.2
Dermatology	219	$42,461	26.9	25.5
Emergency Medicine	382	$49,290	16.9	34.3
Family Practice	1,153	$45,749	17.2	33.3
General Internal Medicine	1,372	$46,714	22.4	33.5
Internal Medicine Subspecialties	734	$46,855	19.0	33.0
Neurology	184	$41,545	11.5	29.3
Obstetrics/Gynecology	884	$50,150	18.6	35.5
Ophthalmology	338	$43,769	30.3	23.1
Pathology	207	$36,609	24.0	19.4
General Pediatrics	841	$43,084	20.7	28.4
Pediatric Subspecialties	198	$47,770	25.3	33.2
Physical Medicine & Rehabilitation	162	$51,162	20.1	38.3
Psychiatry	583	$46,788	21.7	33.3
Radiology	666	$46,045	22.9	30.8
General Surgery	655	$46,450	22.7	31.6
Neurological Surgery	93	$46,640	26.1	35.2
Orthopedic Surgery	511	$44,363	26.3	28.1
Otolaryngology	232	$45,668	24.1	30.5
Thoracic Surgery	72	$50,022	21.7	42.0
Urology	145	$42,325	25.9	25.2
All Specialties	11,617	$46,224	21.2	31.5

Source: AAMC 1990 Graduation Questionnaire

TABLE B12
CHOICE OF SPECIALIZATION OF GRADUATING SENIORS

	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990+
Family Medicine/Practice	17.3	18.2	17.7	17.0	15.9	17.0	18.3	13.6	13.7	--
General Internal Medicine	12.7	13.9	12.7	10.4	10.3	8.3	6.8	7.3	5.3	--
General Pediatrics	8.8	7.5	7.3	7.5	6.3	6.7	6.7	6.6	6.4	--
TOTAL PRIMARY CARE	**38.8**	**39.6**	**37.7**	**34.9**	**32.5**	**32.0**	**31.8**	**27.5**	**25.4**	--
Allergy and Immunology	0.2	0.1	0.2	0.2	0.2	0.3	0.2	0.3	0.7	--
Anesthesiology and Critical Care	4.2	5.0	5.5	6.2	6.6	6.0	6.6	6.7	7.1	--
Dermatology	1.2	0.9	1.2	1.4	1.6	1.8	1.7	2.1	2.7	--
Emergency Medicine	2.8	2.4	2.7	3.0	3.0	3.5	3.7	3.9	4.1	--
Internal Medicine Subspecialties	5.9	3.1	3.7	3.9	4.6	5.0	5.3	6.5	8.6	--
Neurology and Child Neurology	1.6	1.9	1.6	2.1	2.3	2.6	2.0	2.5	2.5	--
Nuclear Medicine	0.1	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.3	--
OB/GYN and Subspecialties	7.9	8.4	7.9	8.8	7.2	7.2	6.7	7.2	6.9	--
Ophthalmology	3.8	3.9	3.8	3.9	4.0	4.2	4.1	4.0	3.9	--
Pathology	2.5	2.7	3.1	2.4	2.1	2.1	2.4	2.1	2.4	--
Physical Medicine and Rehabilitation	0.6	0.6	0.9	0.9	1.3	1.6	1.8	2.1	2.1	--
Preventive Medicine	0.2	0.2	0.1	0.2	0.2	0.2	0.2	0.1	0.4	--
Psychiatry and Child Psychiatry	4.8	5.2	5.0	4.7	6.0	6.6	6.6	7.0	6.6	--
Radiology and Subspecialties	5.3	5.3	6.1	6.5	6.6	6.2	6.9	7.8	7.4	--
General Surgery	6.3	6.0	5.5	6.0	6.1	6.2	5.9	5.4	5.0	
Neurological Surgery	1.3	1.1	1.1	0.9	1.1	0.9	1.2	1.4	1.1	
Orthopaedic Surgery	6.0	6.9	6.6	6.4	6.6	6.7	5.8	6.2	5.9	--
Otolaryngology	2.0	2.5	2.3	2.3	2.6	2.6	2.4	2.6	2.6	
Urology	1.3	1.6	1.8	2.3	2.4	2.1	2.3	1.9	1.8	
Other Surgical Subspecialties*	3.1	3.3	3.4	3.0	2.8	3.0	3.2	3.0	3.3	
TOTAL NON-PRIMARY CARE	**60.7**	**61.1**	**62.5**	**65.1**	**67.3**	**68.7**	**69.0**	**72.9**	**75.2**	--
No Response to Specialty Question	0.6	0.2	0.5	0.4	0.6	0.3	0.1	0.3	0.4	--
Total Number of Students Who Responded to Questionnaire	10,795	10,938	10,481	10,547	11,048	10,739	11,307	10,379	11,175	--
Percent of All Final Year Students Who Responded to Questionnaire	68.8	67.3	65.6	63.6	66.3	66.6	71.6	65.2	71.5	--

+ The format of the specialty choice item on the Graduation Questionnaire was changed in 1990. While the old item asked to select one specialty or subspecialty choice from a list containing both levels of certification, the new item was intended separate choices fro general and subspecialty areas. There were problems with the format of the new question, however, prevented reliable interpretation fo the results. The wording has been revised for the 1991 survey, and new results will be in September, 1991.

* Includes critical care, colon and rectal, pediatric, plastic and thoracic subspecialties.

Source: 1981-1989 AAMC Graduation Questionnaire, Section for Student and Educational Programs

Update: 3/91

TABLE B11
PRACTICE SETTING LOCATION OF GRADUATING SENIORS
PERCENT OF GRADUATES BY YEAR

	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Large city (pop. 500,000 or more)	20.6	20.2	21.1	22.5	21.8	22.6	23.3	22.9	23.7	23.5
Suburb of a large city	10.3	11.5	11.8	13.4	14.1	15.0	16.3	17.5	17.4	18.2
City of moderate size (pop. 50,000 to 500,000)	27.3	28.6	29.0	28.8	29.1	28.8	28.9	29.6	29.9	29.3
Suburb of moderate size city	7.1	7.1	7.0	7.9	7.8	7.9	8.0	8.3	8.5	8.9
Small city (pop. 10,000 to 50,000 - other than suburb)	16.9	16.0	14.6	13.5	12.5	11.9	10.7	9.2	9.1	9.0
Town (pop. 2,500 to 10,000 other than suburb)	6.9	6.5	6.2	5.6	4.8	4.5	3.9	3.2	2.9	2.8
Small town (pop. less than 2,500)	1.3	1.5	1.2	1.4	1.1	1.0	1.0	0.8	0.7	0.7
Rural/unincorporated area	1.1	0.9	0.8	0.8	0.8	0.9	0.8	0.8	0.8	0.8
Undecided or no preference	8.2	7.1	7.5	7.4	7.5	6.6	6.6	7.0	6.5	6.3
No response	0.4	0.7	0.7	0.6	0.5	0.7	0.6	0.5	0.4	0.6

Source: 1981-1990 AAMC Graduation Questionnaire, Section for Student and Educational Programs

Update: 3/91

Mr. **Kostmayer** [presiding]. Doctor.

STATEMENT OF ROBERT GRAHAM

Mr. **Graham**. Mr. Chairman, I am Robert R. Graham, M.D., executive vice president of the American Academy of Family Physicians, presenting testimony on behalf of the American Academy of Pediatrics, Ambulatory Pediatric Association, American College of Physicians, Society for General Internal Medicine, Association of Professors of Medicine and American Academy of Family Physicians. It is a pleasure to appear before the subcommittee today on behalf of the over 180,000 physicians represented by these organizations.

Since many of our views and recommendations are similar to others that you will hear from the panel, I will simply ask the full written testimony be introduced to the record at this point.

Mr. **Kostmayer**. Without objection, your testimony, Doctor, and the testimony of all witnesses before the subcommittee today, will be made part of the record.

Mr. **Graham**. These physicians represented by the organizations that I have mentioned are the physicians that, for the majority of Americans, are their personal physicians. When you ask a member of your family or one of the constituents in your district, "Who is your doctor," chances are their answer will be one of the members of these organizations.

There is no question this type of physician is in increasingly short supply. The efforts of title VII over the last 20 years has been developed, and it has been expanded, have been critical in assuring that there is some maintenance of supply of these physicians within the medical education system that Dr. Stemmler has just outlined to you.

There is no question that it is difficult to attract and retain the interest of medical students today in careers as office-based generalists in an environment where medical education is becoming increasingly technical, complex and based almost entirely on hospital-based patients with multiple system disease.

That is a struggle which we confront collectively. The answers to changing the output of medical schools, in all candor, do not lie entirely within title VII. They lie in further examination of the incentives provided for our medical teaching institutions through the indirect and direct cost reimbursement of medical care, through the influence of biomedical research, but the focus today is what can title VII do and what has it done?

Title VII, as authorized, and even though providing only relatively modest amounts of funds, has provided the opportunity for the Departments of Family Medicine, General Internal Medicine and Pediatrics over the last 20 years to develop innovative and experimental programs to carve out a niche within these tertiary teaching institutions to show what role models of generalists can be and create a demonstrable track record of graduating students who go into residency training and do become the next generation of generalists.

We do not agree with the administration's proposal that support be phased out. Indeed, we believe that this title VII plays a very important role, not a role which may be controlling in terms of the total output of medical schools, but one which we need to have continue to be in place until we can address the broader issues more effectively.

We strongly support, as the organizations represented here, the continuation of the present authorities, the expansion of authorizations in a modest way over the coming 3 to 5 years. There is appended to this testimony some specific recommendations from each of the groups having to do with individual titles, and again, I will simply commend that to you in the record.

I would make as my final comment one I was going to make to the Chair before he was constrained to leave. A week ago, he participated in the press conference with Senator Rockefeller and others announcing an approach to universal access health insurance for all Americans, an objective that most, if not all, in the room agree with.

If they introduced that bill, it had been passed into law immediately, the testimony in the hearing today would have been on the crisis in finding personal physicians and generalist physicians. We have a major issue facing us as we look at access in that once we solve the issues of financing the problem will be there are doctors there for the public to find personal care from.

We believe that is a growing problem, and title VII has a role in addressing it. Thank you, sir.

[The prepared statement of Mr. Graham follows:]

PREPARED STATEMENT OF ROBERT R. GRAHAM

Mr. Chairman, I am Robert R. Graham, M.D., Executive Vice President of the American Academy of Family Physicians, presenting testimony on behalf of the American Academy of Pediatrics, Ambulatory Pediatric Association, American College of Physicians, Society of General Internal Medicine, Association of Professors of Medicine and American Academy of Family Physicians. It is a pleasure to appear before the subcommittee today on behalf of the over 180,000 physicians represented by these organizations.

In spite of an increasing demand for primary care physicians, our organizations are concerned that the supply of these physicians may be falling behind. Primary care physicians provide access to care for minorities, the poor, and those living in inner cities and rural areas, as well as to many of you and your neighbors. By providing comprehensive and continuous care, primary care physicians help prevent debilitating disease, make early detection of disease possible and manage chronic and complex diseases. A rational system of health care depends on a solid foundation of primary care physician providers.

However, the shortage of primary care physicians continues throughout many areas of the country. There are currently some 1,956 shortage areas with approximately 4,100 physicians needed to remove the shortage designations. In addition, it appears there is a continuing and increasing problem of access to physician care for Medicaid recipients, the uninsured and other sectors of the population. The goal of assuring access to quality health care can be met only if the supply of physicians to provide basic health care is appropriate to meet the demand for services. Proposals to expand access to health care must consider the increased demand for health care and the potential lack of availability and accessibility to primary care services.

To assure the most efficient utilization of resources in an expanded health care system, primary care physicians will most certainly play a central role in managing and coordinating patient care. Management of health care services through primary care physician coordination results in the most appropriate mix of services and delivery setting.

Compounding the shortage problem is the adverse trend in primary care career interest among medical school graduates and those entering medical school. The percent of medical school seniors planning to become board certified in a primary care specialty fell from 37.3 percent in 1981 to 23.6 percent in 1989.[1]

There are a number of factors which determine the career choices of medical students including academic prestige of primary care vs. subspecialties within a medical school, the availability of mentors to provide role modeling and nurturing and in some medical schools the selection of medical students. Physician incomes also play a major role in selection of specially and practice location. Low reimbursement for primary care services discourages selection of a primary care career, as new graduates already steeped in debt chose to enter higher paying subspecialties. For the vast majority of medical students, loans are the primary source of financing medical education leaving graduates deeply in debt.

To increase the interest of students in choosing primary care careers, some medical schools have shown that early exposure to primary care and working with primary care role models in ambulatory settings, such as clerkships, is effective. Several recent studies demonstrate that a major factor in career selection for medical students is positive impressions gained during their third and fourth year clerkships in various medical specialties. A positive experience in the primary care rotation, with strong faculty preceptors who also serve as role models, is vital to encouraging medical students to pursue primary care careers. Through these clerkships, students learn that primary care is a rewarding, intellectually challenging field which will enable the physician to be fully involved with the community.

Although such experiences are important in influencing career choice, this type of quality primary care experience is expensive for medical schools to undertake. The teaching of medical students in outpatient primary care settings lengthens patient visits and makes heavier demand on faculty and support personnel than does traditional inpatient training.

Development and teaching of this curriculum is largely the responsibility of faculty in family medicine, general internal medicine and pediatrics. In most medical schools, however, these programs are unlikely to generate substantial revenue from their clinical practice because of current reimbursement policies and are less likely to attract major grant support. Traditional support for medical education has not emphasized primary care, resulting in a dearth of primary care physicians to serve as role models and proponents for primary care. Studies have consistently shown a higher student interest in primary care careers upon entering medical school with an inexorable attrition of interest as they continue through medical school.

Federal support for innovative medical student education in the family practice predoctoral grant programs has been important in the development of ambulatory experiences in family practice for medical students. This needs to be continued and expanded. Authorizing Section 784 grant dollars to be allocated for predoctoral education might enable general internal medicine and general pediatric programs to positively influence medical student choices for careers in primary care.

Strengthening the primary care academic units in medical schools can also increase the visibility, prestige and interest of students in primary care. For example the 50 medical schools with the highest percentage of graduates entering family practice all have departments of family practice. Only 2 of the 20 medical schools with the lowest percentage of graduates entering family practice have departments of family medicine.

Congress recognized the need for more trained family physicians, pediatricians and general internists and authorized support through the Public Health Service Act for primary care training. These grants have funded significant predoctoral, faculty development and residency training programs. Family medicine training grants (Secs. 786 and 780) are separate from general medicine-general pediatrics (Sec. 784), which are combined. Such support has helped to offset some of the financial disadvantage experienced by primary care education programs. According to the Health Resources and Services Administration, since 1986, approximately 2,400 family physicians have graduated annually from accredited family practice residency training programs. Approximately 300 each of general internists and general pediatricians graduate annually from primary care track residency training programs. In the 1980s, federal funding has partially supported about 40 percent of the family practice programs, which train about 50 percent of the graduates. The program currently sponsors 180 projects with 4,177 trainees. The program for general internal medicine and general pediatrics sponsor 86 projects with 91 actual residency training tracks and 1,735 residency trainees (GIM—855, GPD—880).[2]

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[1] Primary Care 2000, HRSA's Long-Range plan for Health Professionals, 1991

[2] Ibid.

The Administration would discontinue federal support for primary care residency programs. The withdrawal of this support would threaten the continued existence of a number of these vital programs and would cause other programs to drastically reduce training levels. Loss of support in other cases could potentially change the nature of the program, for example from ambulatory-based to inpatient-based. Graduate education in primary care is highly dependent upon government support. In most other specialties the costs of graduate medical education are supported by patient care income. The income producing potential in primary care programs is less because the emphasis in these programs is keeping people out of the hospital. In addition, current Medicare payment policies impede ambulatory training. Hospitals are allowed to count the time residents perform patient care activities outside of the hospital only if the hospital incurs all of the training costs in the alternate setting. Because GME must be hospital-based to be subsidized under the existing Medicare methodology for payment, there is a disincentive to sponsor residencies when the hospital does not directly benefit from the residents' labor since it must subsidize the balance of the payment of salaries and fringe benefits as well as training costs in the other setting.

Others advocate that federal financial support be contingent on a community based service linkage. Quality must be a prime responsibility of all medical educational programs. Service is a necessary component of education but not the primary reason for the educational program. Location of education in these settings is highly appropriate, but only when quality is high.

In addition to the above concerns, the organizations represented by this statement have individual recommendations for the various sections of the Public Health Service Act being considered today. These are included as attachments A and B.

SUMMARY

Targeted support for the Title VII programs essential if we are to continue to address the access to health care problems of the nation. The loss of grant support for these primary care training programs would result in a reversal of the many gains in that have been made in specially and geographic distribution. On behalf of the primary care organizations represented in this testimony, we urge Congress to reauthorize the Title VII funds to continue the progress that has been made in educating primary care physicians.

ATTACHMENT A

Recommendations for Sec. 786 and Sec. 780. In order to meet the ever increasing demand for family physicians, a significant increase in federal support is critical. Where other specialties recover a significant percentage of medical education costs through NIH and through patient billings, family practice residency program have greater difficulty in covering their program costs. The American Academy of Family Physicians advocates doubling the current authorizations for family practice residency training (Sec. 786) to $80 million and for departments of family medicine (Sec. 780) to $14 million. These funds provide support to train residents to become family physicians, to develop faculty in the specialty of family practice and to create and strengthen departments of family medicine within medical schools to ensure that students are exposed to family practice as a viable career choice.

ATTACHMENT B

Recommendations for Sec. 784. The American Academy of Pediatrics, the Ambulatory Pediatric Association, the American College of Physicians, the Society of General Internal Medicine and the Association of Professors of Medicine support the following request for Section 784:

As discussed in the joint testimony, data and experience indicate that positive clerkship experiences in primary care do influence career selection. Accordingly, we recommend that the Title VII reauthorization legislation include language establishing predoctoral clerkships for general internal medicine and pediatric programs to be funded at $2 million for fiscal year 1992, $3 million for fiscal year 1993, and $4 million for fiscal year 1994. Such predoctoral programs are already authorized for family practice under the current legislation and have proven quite successful.

The federal government and the institutions training the next generation of health professionals must continue the partnership to reduce the deficit of primary care physicians and meet the health care needs of our local communities. Although achieving this will entail an increased financial commitment, we are not asking Congress in this period of limited financial resources to assume a disproportionate share of the cost of achieving our mutual goal. Over the life of the reauthorization we seek a $16 million increase, $9 million of the increase to fund a new predoctoral clerkship program. Specifically, we request the Committee to authorize the following levels: for fiscal year 1992—$27 million, fiscal year 1993—$31 million, fiscal year 1994—$36 million. We strongly believe that the goal to meet the national primary care shortage justifies this moderate increase in general internal medicine and pediatrics.

Mr. KOSTMAYER. Your implication, is that Chairman Waxman's legislation would deal with the financial issues, but not necessarily with the shortage of physicians?

Mr. GRAHAM. Absolutely. I commend him for the legislation, but simply saying if that had gone into effect and had all the positive outcomes he would wish in terms of providing financial access, we now have 30 or 40 million more Americans who would be looking for more primary care physicians we believe they would be hard-pressed to find.

Mr. KOSTMAYER. You are not suggesting that is a problem created by the bill?

Mr. GRAHAM. No. It is true and unrelated.

Mr. KOSTMAYER. The American Academy of Family Physicians supports the Waxman-Rockefeller bill?

Mr. GRAHAM. We have our own bill that is based upon many of the same principles. I would say if their bill or our bill were enacted in law tomorrow, it would be a better America.

Mr. KOSTMAYER. Thank you.

Dr. Richards.

STATEMENT OF DAVID M. RICHARDS

Mr. RICHARDS. I am David M. Richards, D.O., president of Texas College of Osteopathic Medicine in Fort Worth. I am also the chairman of the board of governors of the American Association of Colleges of Osteopathic Medicine, which represents the 15 colleges of osteopathic medicine and their 6,615 medical students.

I am pleased to be here with Andy Morales, who will begin his fourth and final year at my school in August. We will try to describe what you have called "secrets of our success": Our ability to produce significant numbers of primary care graduates.

Our first "secret": My State-supported school and the other five State and nine private colleges of osteopathic medicine have a unique approach to recruiting students. We are all willing to look at more than just good scores on the Medical College Admissions Test and science GPA's in order to identify good future osteopathic physicians.

Our student bodies include many older, or so-called nontraditional, students with advanced degrees.

Currently, there are 2.6 applicants for each slot at our schools. We just experienced a 22-percent increase in applications over last year. Osteopathic medicine is the fastest growing health profession, so we must be doing something right.

Our second "secret": We require references from at least two osteopathic physicians so that the interested candidate fully understands what he or she is getting into. This exposure helps us determine if the student accepts two important osteopathic philosophies:

One, his or her role in addressing our holistic approach and the integral role that the musculoskeletal system—the muscles, bones and joints—plays in total health; and, two, the role the patient must play in his or her own health maintenance.

Our third "secret": Our success in graduating more primary care physicians is directly related to the required core clinical clerkships in ambulatory training in rural and inner city clinics, private physicians' offices, community health centers, and in geriatric settings.

Clinical experiences in small communities also provide our students with valuable insight to the challenges and rewards of practice in small, medically underserved communities.

It is my opinion that these three "secrets" are why 80 percent of TCOM graduates practicing in Texas, and 76 percent of TCOM graduates elsewhere in the United States, are in primary care practice.

However, for osteopathic schools to continue their historic primary care commitment, we must be able to attract students who share our goals and who can expect to graduate and enter practice with manageable debt.

Our students' debt levels have increased significantly over recent years because of the increased cost of loans and the declining number of scholarships. Much of this is due to the lack of State appropriations at many of our schools, little or no cross-subsidies from faculty practice income and, therefore, our need to rely on tuition to a much greater extent than the average M.D. medical school.

Unfortunately, Mr. Chairman, while 58 percent of all D.O.'s in practice are currently in primary care, only 41 percent of the Nation's 1990 D.O. school seniors expressed an interest in primary care when they were surveyed last year.

With this increasing debt, which now averages more than $71,000, compared to $46,000 for M.D. students, we are disappointed, but not surprised. To help understand why, it is important to know that 48 percent of our entering students come from families with annual incomes of less than $40,000.

AACOM opposes the administration's budget request to eliminate the HRSA programs that support primary care. We believe they should be continued as complements to the administration's strong support for minority and disadvantaged assistance, as well as the Resource-Based Relative Value Scale reorientation in physician payment, which is designed to "level the playing field" between the specialties and primary care.

I know that you, Mr. Chairman, have been a strong supporter of increasing payments for primary care relative to specialty care and for fixing the current imbalance. These HRSA programs are "small potatoes" in relative dollar terms, but big in impact at the Nation's osteopathic medical schools.

Without critical and healthy support of these HRSA programs, the maintenance or establishment of predoctoral and postdoctoral training programs would not take place.

I would be remiss if I didn't take a few moments to tell the subcommittee how important the HEAL and HPSL loan programs are to osteopathic medical students. First, for many of our students, at private schools particularly, they must borrow HEAL money to the max. Many do this as early as their freshman year.

Osteopathic medicine has the lowest HEAL default claims profile of all eligible disciplines, even though our students are, on average, the most indebted. HEAL must be preserved.

The Health Professions Student Loan Program, or HPSL, is woefully underfunded, but it has proven itself many times over. It should be reauthorized and receive major recapitalization. We believe it is a model that should be used to assess the HEAL program.

Thank you. I would now like to introduce you to student doctor Andy Morales.

STATEMENT OF ANDREAS G. MORALES

Mr. MORALES. Good morning, Congressman Kostmayer and members of the subcommittee. My name is Andreas G. Morales. Next week, I will be a fourth year student at Texas College of Osteopathic Medicine. You have asked why I want to be an osteopathic physician.

I have always wanted to find a vocation that would allow me to truly develop my fullest potential as an individual, one in which I believed my contribution to society would really make a difference. This is particularly important to me as an Hispanic.

When applying for medical school, I was impressed with the faculty and students of TCOM who encouraged me and other applicants. I was impressed that they were interested in me, my family and my Hispanic background.

I like TCOM's philosophy of preventive medicine and the concept of a D.O.'s partnership with his or her patients. There is a true sense that osteopathic physicians are trained to be personal with patients, not aloof.

Osteopathic medical schools emphasize primary care when they recruit. They look positively on second-career students. On average, osteopathic medical students are older than M.D. students. They bring their experiences from a previous career to provide more comprehensive health care to their patients.

I would like to say here that the majority of Hispanic students at TCOM, as well as other minority students, are in the top 25 percent of their respective classes. The great majority of these students also intend to enter primary care. This is a testament of TCOM's commitment to provide for the medical needs of the lower socioeconomic and minority communities in Texas.

As Dr. Richards stated, debt levels are quite high for many osteopathic medical students, especially those who want to become primary care physicians. I was really quite distressed to learn that although 58 percent of all D.O.'s are in primary care medicine, only 41 percent of last year's seniors expected to specialize in primary care.

Although a large majority of those seniors said that a heavy debt load was not a major factor in their specialty choice decision, it is known that those with both high debt and high income expectations are more likely to choose nonprimary care specialties.

HEAL loans have come essential for the majority of D.O. students, not because they are so great from an interest rate standpoint, but because they have become necessary for us to complete medical school and to enter primary care residencies. Targeted subsidies to primary care, such as lower cost loans or tax incentives, might be part of the solution.

For osteopathic medicine, which has the lowest HEAL default claims record relative to loan volume, it would be tragic if the HEAL loan program were phased out, particularly if it means that new osteopathic borrowers, such as this fall's freshmen, could not borrow, or couldn't get the lower cost HEAL loans available through the Kirksville College of Osteopathic Medicine.

Our ability to continue to play a major role in the solution to our country's primary care physician shortage would be hurt tremendously.

You asked about the impact of debt on specialty choice. For many of my fellow students, as well as myself, it is likely to have a very big impact. Half my class is married, many have children. Many students are choosing, or say they may choose, nonprimary care specialties and subspecialties if they have high debts.

To get ready for this hearing and to give you a man-on-the-medical-school-street assessment of debt in primary care, I talked to primary care doctors in Texas who are having a very difficult time because of lingering debt loads.

One thing is that out-of-pocket overhead costs for subspecialists are lower than they are for primary care physicians. That is because GP's and FP's are often freestanding, requiring the physicians to invest in equipment themselves, rather than a hospital doing it.

It helps that TCOM's tuition is State-subsidized, which is not the case for many students in several colleges of osteopathic medicine. However, after only 3 years of medical school, I have now accumulated debts of $52,000, and I expect to graduate with debts of about $80,000. I also am married and have a child.

My wife works and goes to college, too. My HEAL debts already total about $15,000. I expect to borrow more HEAL money for my last year of medical school. I am concerned, however, because of the "cap" on HEAL funds and the fact that funds are expected to run out within a few weeks.

I am still planning to enter general internal medicine and eager to establish a practice to serve Hispanics. However, because of debt, overhead costs, and my need to help my younger brothers through school, I haven't ruled out neurology.

If I go into primary care, my plan is to pay back my loans in 8 or 9 years. But, if I go into a subspecialty, it will take me only half the time. So, Congressmen, you see my dilemma. Thank you.

Mr. KOSTMAYER. Thank you very much. Doctor Gershen.

STATEMENT OF JAY A. GERSHEN

Mr. GERSHEN. Thank you, Mr. Chairman.

I am Dr. Jay Gershen, professor and Chair of public health dentistry at UCLA. I appear today as president of the American Association of Dental Schools. I am pleased to have the opportunity to present AADS's recommendations concerning the General Dentistry Residency Program and the Health Education Assistance Loan Program.

General dentistry residency programs provide dentists with the skills needed to treat patients requiring specialized or complex care. These patients include the elderly, the handicapped, developmentally disabled individuals, high-risk medical patients, and those with infectious diseases.

Eighty-six percent of those who receive general dentistry training remain primary care providers; the enrollment rate of black dentists in recently funded general dentistry programs is 13.4 percent, and the enrollment rate of Hispanic dentists is 7.8 percent.

One-third of current grantees include offsite rotations to underserved communities or populations. For example, a New York City general dentistry program served five community health centers, and a program in Colorado has established rotations throughout the State, to community, migrant and rural health centers.

General dentistry programs are required to become self-sufficient within a 3-year "startup" time. This is a significant challenge because reimbursement for dental services through Medicare and Medicaid is limited. General dentistry programs must attract enough self-pay patients and patients with dental insurance to offset the losses incurred in treating the indigent.

The AADS requests expansion of this program to more adequately meet the demand for training. Currently, one of three dentists seeking a general dentistry residency position is turned away. We urge the subcommittee to reauthorize the general dentistry program at $8 million, $10 million and $12 million for the next 3 fiscal years.

Next, I will turn to the HEAL program. AADS is extremely concerned that everything possible be done to assure that HEAL borrowers meet their obligation to repay these loans. As you have heard today, the HEAL program has an overall default rate of 8.2 percent, and the rate for dental students is 10.6 percent.

Most dental defaults occur in the initial years of repayment. The overwhelming majority of these defaults occur because the young dentist's earnings are low as compared with his or her educational debt.

Most of these borrowers are not unwilling to pay. Nor will their earnings remain insufficient to meet their student loan obligations. Rather, there appears to be a temporary imbalance between debt and income, which can be remedied by providing alternative repayment options. These include consolidation of HEAL loans and the provision of graduated repayment terms.

In the HPSL program, for example, schools are allowed to provide alternative repayment options and work with borrowers to assure repayment. In contrast to HEAL, the HPSL default rate for dental students is 2.1 percent.

AADS urges the subcommittee to require more of all parties involved in the HEAL program.

For schools, we support the imposition of a reasonable and fair performance standard for participation in the HEAL program.

Schools must be allowed to be actively involved in collection. This includes informing delinquent borrowers about the negative consequences of default. Currently, schools are prevented from making any such negative statement. This effectively ties one hand behind their back.

Under the performance standard, it should be possible to "cure" a defaulted loan. Under the current HEAL calculations, once a claim has been paid for a defaulted loan, that loan is forever counted as a default, even if the borrower subsequently gets back into repayment.

Within the Department of Health and Human Services, a new office should be established. This office should track HEAL loans, interface with the Department of Education and the Department of Justice, improve collection efforts, and centralize the deferment process. This office would make sure that HEAL loans are not "lost in the system" after a claim has been paid.

We believe that the cost of establishing this new office would be more than covered by what is saved in cured loans and in collections recovered from defaulted loans.

For lenders, additional due diligence requirements should be imposed so that written and telephone contacts begin earlier in the HEAL collection process. We also recommend exploration of an incentive program that would provide positive financial incentives for lenders who keep their defaults below a predetermined goal.

Finally, while I was asked to discuss the HEAL program, in closing I want to congratulate and thank the subcommittee for the Health Professions Student Loan Program. This is widely considered to be a model student loan program.

It provides low interest loans to students, great flexibility for schools that administer the program, and has an extremely low default rate.

We urge the subcommittee to provide the highest possible authorization for this outstanding program. Thank you for the opportunity to present our views. I would be pleased to answer your questions.

[The prepared statement of Mr. Gershen follows:]

PREPARED STATEMENT OF JAY A. GERSHEN, ON BEHALF OF AMERICAN ASSOCIATION OF DENTAL SCHOOLS

The American Association of Dental Schools [AADS] represents all of the dental schools in the United States, as well as advanced education, hospital, and allied dental education institutions. It is within these institutions that future dental practitioners, educators and researchers are trained; significant dental care provided; and the majority of dental research conducted. The AADS is the one national organization that speaks on behalf of dental education.

Our Association is pleased to present these written comments for the record in preparation for oral testimony to be delivered before the Subcommittee on May 30, 1991 by Dr. Jay A. Gershen, Professor and Chair, Public Health Dentistry, UCLA, and President, AADS. These comments concern the General Dentistry residency program and student assistance, focusing on the Health Education Assistance Loan program. After the hearing, we will submit additional comments for the record concerning other major programs to be reauthorized as part of Title VII of the Public Health Service Act.

Primary Care: General Dentistry Residencies

General dentistry residency programs provide dentists with the skills and clinical experience needed to treat elderly patients and other individuals recurring specialized or complex care, such as the handicapped, developmentally disabled individuals, high risk medical patients, and those with infectious diseases. These residency programs can be compared with the type of training physicians receive during their internship year.

The General Dentistry Program meets the federal objective of increasing access to primary care, in a cost effective manner. Eighty-six percent of those who receive General Dentistry training remain primary care providers. Additionally, while in training, residents provide oral health care to underserved populations and communities. The need to recruit and enroll minorities into this training has been recognized and is being addressed.

This primary care residency trains dentists to provide a broader range of services to their patients and to consistently refer fewer patients to specialists. This is especially important to the indigent, medically compromised patients, and people in rural areas, since these patients often face financial or logistical problems that make specialized care unobtainable.

In fiscal year 1991, $3.9 million was made available for General Dentistry grants. Fifty-five dental schools and over 500 hospitals are eligible to compete for this funding; the schools alone would have needed over $30 million last year to meet their goals for initiation or expansion of General Dentistry programs.

One third of current grantees include offsite rotations to underserved communities or populations. These rotations give general dentistry residents experience in caring for patients at community health centers, nursing homes, geriatric day care facilities, state institutions, and children's hospitals. For example, a New York City general dentistry program serves 5 community health centers and a program in Colorado has established rotations throughout the state—to community, migrant, and rural health centers.

Recognizing the need to increase General Dentistry trainees from minority populations, federally funded programs have actively recruited and enrolled Black and Hispanic dentists. Such programs enrolled 13.4 percent Black dentists and 7.8 percent Hispanic dentists in 1989. The enrollment rate of Black dentists in recently funded General Dentistry programs is more than twice the graduation rate of Black dentists.

As a result of federal support for general dentistry residency programs over the past 13 years, 48 new programs have been created and 385 new training positions have been established. Between 1977, the year before federal support began, and 1990, there has been a 62 percent increase in the number of positions established. However, the demand for training has far outpaced the initiation of new positions, as new, dentists seek to develop the skills to care for the changing oral health needs of the nation's population.

General dentistry residencies prepare dentists to treat medically compromised patients: individuals suffering from diseases such as diabetes, cystic fibrosis, and rare or so-called orphan diseases and conditions such as ectodermal dysplasia, Sjogren's syndrome, and cleft lip and cleft palate; elderly patients whose treatment must often be significantly altered because of their medical history; individuals who suffer oral complications because of cancer chemotherapy or radiation to the head or neck; patients with primary oral conditions such as oral cancers and certain chronic pain conditions; and patients who need major facial reconstructive surgery because of developmental disorders or trauma.

In 1990, approximately one out of every three applicants for dental general practice residency positions was turned away. The continually increasing demand for this training is strong testament to its value. Both the AADS and the American Dental Association support the creation of additional training positions so that every dentist who seeks such training can be matched with a position.

The General Dentistry program is very cost effective. This efficiency is achieved by requiring programs to become self-sufficient within a three-year "startup" timeframe. This requires considerable skill, as the General Dentistry program must attract enough self-pay patients and patients with dental insurance to offset the losses incurred in treating the indigent. Unlike their medical counterparts, these dental residency programs cannot rely on reimbursement through Medicare, which essentially excludes dental services, and the reimbursement available through Medicaid is extremely limited, if available at all.

The AADS requests expansion of this program to more adequately meet the current demand for training. There is no question that dentists who have had the benefit of advanced training are better prepared to provide comprehensive dental services, and are less reliant on referring patients to specialists. The programs that have been funded in recent years are expanding their reach to offer trainees a wide range of didactic and clinical experiences in a variety of hospital and community settings. This approach exposes trainees to a full mix of patient needs, and affords them the opportunity to meet with medical colleagues in appropriately integrating medical and dental care.

We urge the subcommittee to reauthorize the General Dentistry program at $8 million, $10 million and $12 million for the next three fiscal years.

Student Assistance: Health Education Assistance Loans

Background:

The Health Education Assistance Loan [HEAL] program was established as a loan "of last resort" for health professions students. Students of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, public health, health administration, clinical psychology, chiropractic and allied health are currently eligible to borrow under this program.

Students turn to these loans when they have exhausted their eligibility for grants and low cost loans. To be eligible to receive a HEAL loan, the student must meet the same needs test that is used for the Guaranteed Student Loan programs.

The HEAL program provides a federal guarantee to loans made by private lenders. HEAL loans are unsubsidized; the borrower pays interest equal to the average 91-day Treasury bill rate plus 3 percent, adjusted quarterly. Interest is generally compounded semiannually. Currently, borrowers pay an insurance premium of 8 percent, which is deducted from the face amount of the loan. During the time when the borrower is in school and in residency training, interest is compounded and accrues.

As of September 30, 1989 over 100,000 health professions students had borrowed more than $1.8 billion in HEAL loans.

When the program was established, it was to be used to "fill in" the gap that existed—especially in private schools—between loan limits and borrower needs. The HEAL loan was never intended to be the mainstay of a borrower's loan portfolio. Rather, grants and low-interest (subsidized) loans were to comprise the majority of student financial aid. The Middle Income Student Assistance Act [MISA] had just been passed, and Guaranteed Student Loans were to be an entitlement to all students except those whose families were in the top 25 percent of all income earners.

Because the HEAL loans were to be used in this limited way, it was expected that the borrower would bear the full weight of program costs. The insurance premium assessed was to cover defaults due to death, total disability and inability to pay. The borrower was assessed all interest charges. Thus, unlike any other federal financial aid that existed at the time, the HEAL program was totally unsubsidized; when the student was in school or residency training, interest was assessed to the borrower's account.

Unfortunately, however, MISA was never implemented, due to federal budgetary constraints; the needs test for the Guaranteed Student loan was tightened so that only those from families earning $30,000 per year or less would qualify.

With access to student financial aid diminishing each year, the "loan of last resort" came to play an increasing role in financing a health professions student education. It was only a matter of time before those who had been forced to rely on HEAL loans realized the cost of an unsubsidized loan. Concern was raised from borrowers, financial aid administrators and the Administration about how expensive the HEAL loan is. Yet there was no suggestion that, as in other federal loans, the government could subsidize HEAL loans, thereby lowering the cost to students.

Although it is not reasonable to expect the HEAL program to cost the federal government nothing and at the same time be a bargain for the borrower, the program has been widely criticized for failing to meet these two conflicting objectives.

Much attention has been directed to the HEAL program recently, because of the program's default rate, which has triggered fears that substantial appropriations will be required to pay off ever-increasing claims.

The costs attributed to the HEAL program include the "residual" problem of an underfunded Student Loan Insurance Fund [SLIF]. This occurred in the initial program years, when the insurance premium charged to borrowers was less than 1 percent.

Currently, borrowers pay an insurance premium of 8 percent and the program has an average default rate of approximately 8 percent. Higher education consultants state that the current insurance premium should be more than sufficient to cover defaults, if the residual deficiency were taken care of.

AADS comments:

AADS has the following recommendations concerning the Health Education Assistance Loan [HEAL] loan program and its relation to other student assistance programs: (1) the Administration's proposal to terminate the HEAL program should be rejected; (2) the Health Professions Student Loan [HPSL] program should be expanded; (3) a new Direct Loan Program, modeled after HPSL could offer an attractive alternative to HEAL; and (4) the HEAL loan program can be significantly improved.

The Administration's proposal to terminate HEAL should be rejected

The President's fiscal year 1992 budget request proposes a three year phaseout of the HEAL program. Instead, $15 million would be made available to disadvantaged health professions students.

We question the justification for this proposal, as we believe that the losses projected for the Student Loan Insurance Fund, which are the foundation for the Administration's recommendation to terminate the HEAL program, are overstated. For example, to date, the Administration's forecasts have not projected any recovery on any defaulted HEAL loans. We believe that the majority of defaulted loans should be able to be recovered, if sufficient diligence is applied.

The Administration's plan would leave all but a few students to fend for themselves in trying to replace an average of over $8,000 per year in borrowing capacity. This would certainly cause applicants to the health professions—including the minority students we are diligently trying to recruit—to question the government's commitment to student aid.

We urge this Subcommittee to reject the Administration's plan, because many low- and middle-income students will be left without resources sufficient to cover their costs if this course is taken. Tens of thousands of health professions students will be forced to turn to even more expensive loans, if they can find lenders willing to make a loan to a borrower without collateral.

Instead, AADS urges the Subcommittee to further improve the HEAL program, as detailed below. At the same time, the Health Professions Student Loan program should be significantly expanded, or a Direct Loan Program created.

The Health Professions Student Loan program should be expanded

The HPSL program, which provides loans to medical, osteopathic, dental, veterinary medical, pharmacy, podiatric and optometric students, is widely considered to be a model student loan program. The program has a default rate of only 1.9 percent. This low default rate is especially impressive, because HPSL borrowers come from financially needy families. Thus, these borrowers are greater credit risks than the "average" HEAL or GSL borrower.

Private funds are not involved in the HPSL program. The loan funds were made available by a direct appropriation from the federal government, which provided 90 percent of the revolving loan fund; schools provided a 10 percent match.

The schools make and service the loans and are allowed to recover only small administrative costs. Schools have flexibility in administering and collecting the loan funds. For example, the borrower's repayment schedule can be adjusted, with payments decreased or temporarily suspended if the school determines that this is necessary, given the borrower's financial situation.

Borrowers are currently charged only 5 percent interest. No interest is charged while the borrower is in school or during the first 4 years of residency training.

In the year ending June 30, 1990, the HPSL revolving fund made available just over $71 million to nearly 22,000 borrowers, who took out HPSL loans averaging $3,250 each.

While the HPSL program provides low interest loans (and therefore significantly lower costs) to students, great flexibility in administration, and an extremely low default rate, there is currently no authorization for additional federal capital contributions.

We urge the Subcommittee to authorize the highest possible authorization for this outstanding loan program.

A Direct Loan Program could offer an attractive alternative to HEAL

An alternative approach would be to establish a Direct Loan Program which would be administered almost exactly like the HPSL program. Under the Direct Loan Program, however, the loan proceeds would be due to be repaid to the federal government and would not become part of a permanent revolving fund.

This approach has appeal because, under the new credit reform provisions of the 1990 Budget Reconciliation Act, direct loans are recognized as less costly than guaranteed loans. New budget scoring takes into account the full costs associated with guaranteed loans, and, by comparison, shows the benefits of direct loan programs.

Further, a Direct Loan Program for health professions students could serve as a test model to see if a direct loan program could be more broadly applied to federal student financial aid. By borrowing directly from the federal government rather than through private lenders, very significant federal savings could result.

The HEAL program can be significantly improved

While we enthusiastically support expansion of the HPSL program or development of a Direct Loan Program, the HEAL program still can and should be improved. Schools, lenders, and the administration all have responsibility for assuring that over $2.2 billion in federally guaranteed HEAL loans are diligently pursued and collected.

For schools we support the imposition of a reasonable and fair performance standard on schools participating in the HEAL program.

(1) We urge that the HPSL default calculation, as currently specified in statute, be applied to the HEAL program. As with the HPSL program, it should be possible to "cure" a loan for which a claim has been paid, if the loan subsequently comes back into repayment. (Under current HEAL calculations, once a claim has been paid for a defaulted loan, that loan is forever counted as a default, even if the borrower subsequently gets back into repayment!)

(2) Schools must be allowed to be actively involved in collection, as they are in the HPSL program. For example, schools should be allowed to tell delinquent borrowers about the negative consequences of default. (Currently, schools are prevented from making any such negative statement. This effectively ties one hand behind their backs.)

We must, however, express concern about the fact that there is only one major secondary market for HEAL loans. The Student Loan Marketing Association (Sallie Mae) currently holds at least 68 percent of all HEAL loans. So long as all lenders sell their HEAL loans to the same holder, how can schools shop for better servicing? We urge the Subcommittee to consider ways to stimulate competition at the secondary market level. This, in turn, could allow competition to reemerge among lenders.

It is critical that a new office be established at DHHS to track HEAL loans, interface with the Department of Education and the Department of Justice, improve collection efforts, and centralize the deferment process.

It is important that HEAL loans not be "lost in the system" once a claim has been paid. Since only a few HEAL defaulters fail to graduate, it is likely that even those who initially experience a very high debt-to-income ratio, will eventually be able to repay their loans. Thus, it should be possible to collect on the vast majority of HEAL default claims, if the judgments are diligently pursued.

This new office should also undertake a thorough review of current collection requirements and incentives, and recommend additional steps to improve loan servicing and collections. A significant number of "technical defaults" occur, for example, when borrowers fail to file the proper deferral forms. Yet, the lender cannot be paid without taking that loan through litigation. How can a loan go through litigation without the lender finding out about the need to file a deferral form and working with the borrower to get it done? (Why is it seemingly easier to proceed through litigation than to file a form?)

We urge that DHHS be directed to hire at least five persons who are exclusively accountable for the above-mentioned functions, and who must report annually to this Subcommittee. Further, we urge the Subcommittee to examine the authority DHHS has to pursue delinquent loans prior to default, in order to assure that office of sufficient power to be effective. We believe that the cost of establishing this new office would be more than covered by what is saved in cured loans and in collections recovered from defaulted loans.

Additional requirements should be imposed on lenders so that the HEAL collection process begins earlier. More frequent written notice and earlier telephone contacts should be required, so that HEAL "due diligence" efforts more closely parallel those used by a number of banks in pursuit of their own loans.

An incentive program should be explored that would provide positive financial incentives for lenders that keep their defaults below a predetermined goal. The default goal could be negotiated annually with each lender. Such positive reinforcements could help further lower defaults.

Loan repayment should be related to borrower's income. By allowing HEAL loans to be consolidated with other federal loans, it should be possible to establish graduated repayment plans geared to the health professions.

Borrowers should be protected against high interest rates with an interest cap. We urge the Subcommittee to limit the amount of interest that a HEAL borrower can pay to 12 percent. If the interest exceeds that amount, the federal government would pay the amount in excess of 12 percent. This has been done for the Supplemental Loans for Students program, administered by the Department of Education.

Finally, the insurance premium should be examined, and a fair premium should be assessed, based on a comprehensive analysis of the risk of defaults, deaths and total disabilities. Such a premium must be determined with a forecast that projects income due to collections from former defaulters.

As with any insurance system, care must be taken to avoid continually increasing the insurance premium charged to the consumer—in this case the borrower. Congressional oversight is required to assure that lenders and the administration are doing everything possible to collect from prior defaulters.

AADS appreciates all that this Subcommittee has done to promote the nation's health. We look forward to working with the Subcommittee during this reauthorization process.

Mr. **Kostmayer**. Thank you.

Dr. Stemmler or Dr. Graham, I understand that in 1990, only 55.7 percent of available family practice resident physicians were filled by graduates of U.S. medical schools. Can you tell us how elimination of these programs as proposed by the administration would affect the number of primary residency slots available and thus, the number of primary physicians entering?

Mr. **Graham**. Purely as it relates to family medicine, approximately 50 percent of all first-year positions have some degree of title VII support at the same time. It would not be candid for me to suggest if title VII went to zero next year all those positions would close down immediately. But for some of the reasons I alluded to in my remarks it would make it doubly difficult to maintain the number of family residency training programs.

I would expect we would see an attrition of at least 30 to 40 percent of those positions in the first year, and where we went after that would depend on where the other sources of funding came and what other changes there might be in Federal support for graduation.

Mr. **Kostmayer**. You mean 40 percent of those 2,500 medical students would drop out?

Mr. **Graham**. I am sorry. I misunderstood. I was addressing only the residency level which is after they graduate. I am saying we would lose—of those current residency positions about half are federally supported through title VII. I am saying in the first year I think we would lose around 40 percent—half. Immediate 20 percent reduction in available positions for family medicine.

Mr. **Stemmler**. Let me just respond in a slightly different way. That is to identify those programs that are supported out of title VII in a sense as an infrastructure in this country for the training and education of people in the primary care specialties.

I think what is so important in this renewal is the fact that there are movements now being initiated or ongoing as was mentioned earlier by some of the private foundations which when looked at collectively, the Federal investment as well as the private investment, at least it sets the stage potentially for some accomplishments that have not heretofore been available to us. I am not answering in detail on the technical part of your question but really in the importance of what title VII does in supporting that infrastructure.

Mr. **Kostmayer**. Do you think if the HEAL Program were eliminated, medical and dental students would be able to obtain alternative financing?

Mr. **Stemmler**. I have great fear about the elimination of the HEAL Program. Incidentally, my prior life—just prior to this last July I was the Dean of the School of Medicine at the University of Pennsylvania, so I associated myself very strongly with your analysis.

We need every source of loan funds and scholarship funds in order to support medical education, unquestionably and without a doubt. Although it is true there are initiatives such as the medical loans program, it is a series of pieces that has to be put in place to maintain a policy in this country that medical education is available to anyone who is bright enough and qualified enough to study.

Mr. **Kostmayer**. You don't think that gap would be filled?

Mr. **Stemmler**. I don't think that gap would be filled, no, sir.

Mr. **Kostmayer**. To what extent?

Mr. **Stemmler**. I have no way of estimating that. It has not been easy to obtain lenders that will support that particular device for student loans. To just speculate the banks are going to be there to support that I think is highly speculative.

Mr. **Kostmayer**. The President's budget for 1992 would reduce the current 1991 budget by $184 million down to $88 million. That would be targeted for a limited number of programs for disadvantaged and minority students. While the subcommittee has never supported these extreme reductions in funding, we are interested in your comments on the priorities outlined in the President's program. Do you think it is appropriate to limit the support for only these narrow purposes?

Mr. **Gershen**. If I may comment. It seems to me that would create—only the rich or very poor could obtain a loan and afford a medical or dental education.

Mr. **Stemmler**. We believe very strongly—and I personally believe very strongly—in what I would call needs-based functional aid, and obviously individuals who have greater needs—those loans or scholarships should be provided not based on a priority relative to an ethnic consideration or racial consideration but based on financial need.

And I think there are other initiatives that we clearly have to respect in medical education that have to do with the representation of individuals in society in our profession. When we are talking about financial aid we rest on needs analysis and providing aid on the basis of need.

Mr. **Kostmayer**. Do you think your views generally are shared in the medical community about the Administration's proposals?

Mr. **Stemmler**. Yes.

Mr. **Kostmayer**. What do you think possessed the Administration to come up with these extraordinary proposals?

Mr. **Stemmler**. Mr. Kostmayer, I would not want to speculate on the intent of the Administration. We heard their testimony earlier.

Mr. **Graham**. I may be in a unique position to speculate since my job prior to coming to this one was Dr. Harmon's position.

The long standing position of the administration since 1980 has been to zero out these discretionary programs, believing in times of tight budgetary constraints that is not a high public priority. I believe what you heard from the panels this morning and what you will hear more this afternoon as you get into title VIII there is a compelling argument that can be made to increase the numbers of disadvantaged and minority students in health professions education across the board. That goes very strongly to the arguments for student assistance.

Over and above that, there are needs for the support of continuing to produce needed type of practitioners. Primary care physicians is certainly one area.

I think you will hear from the nursing community later on this afternoon. The fact both of those may be public needs I believe does not lead to an argument. You should combine them and only have primary care for minority and disadvantaged students. I think you need to keep those two things separate. I understand the administration's argument. I do not happen to support that proposal.

Mr. KOSTMAYER. You felt that way in your previous position?

Mr. GRAHAM. My previous position was to do the best job I could to make sure the committee understood the President's budget.

Mr. KOSTMAYER. But you had to convey the administration's view.

Mr. GRAHAM. Absolutely. That is what you expect from an administration witness.

Mr. KOSTMAYER. Which you did not agree?

Mr. GRAHAM. I had some personal disagreements.

Mr. KOSTMAYER. Explain to me from your personal perspective why the administration is doing this.

Mr. GRAHAM. With due respect to the budget process which this administration is presently operating and recognizing, the people of different parties have different views of the public role.

Mr. KOSTMAYER. There doesn't seem to be any disagreement in the medical community. It seems to me—this is why I asked the question. These views towards the administration's proposals are generally shared in the medical community. Everybody nodded their head.

Mr. GRAHAM. I think there is a generally strong view within the health professions community that the present authorization levels of title VII and title VIII programs are minimal at best, that the authorization should be continued, probably with some modifications.

Mr. KOSTMAYER. The administration would cut them below current levels.

Mr. GRAHAM. That is correct, and my interpretation now as a participant observer is the administration's philosophy has been that there is not a compelling public role in this area so you are hearing a debate between groups of interest about whether or not there is a compelling public role.

Mr. KOSTMAYER. Not a compelling public role to provide tuition assistance to finance?

Mr. GRAHAM. I believe on the face of it that argument is consistent with the administration's proposal to you.

Mr. KOSTMAYER. Is that the arguments they made to you when you held the position?

Mr. GRAHAM. Certainly the feeling has been that if you look at the earning capacity—and I don't need to go back to 1982, I have done this before—if you look at the earning capacity of health professionals, they tend to be among the relatively privileged class of our society, and if you are sitting down and doing a tough budget that you may well be looking more at the income maintenance needs of individuals who are not health professionals.

I think it is a legitimate area for public debate.

Mr. **Kostmayer**. That seems to make some sense. Why don't you share that point of view that doctors indeed make a great deal of money when they graduate, and, therefore, they should be less dependent on these kind of programs?

Mr. **Graham**. Were the venue for the hearing different and I were to be called before you for a different purpose, I might well share some of those views. I am before you as a representative of five organizations, and I think it would not be fair to them to simply reflect what might be a personal view of better public policy.

Mr. **Kostmayer**. Mr. Morales, you are paying for your education. Can you tell me how you are paying for your education? Are you using these programs?

Mr. **Morales**. Yes. Fortunately, I was able to finish my undergraduate career with no indebtedness. My parents helped me. And I worked three jobs. I went to the University of Texas, El Paso. During medical school I have been funding my career through Texas guaranteed student loans and the HEAL Program. That is—I have also been subsidizing my income with the Perkins Loan as well.

In talking to several students I asked them what would they do if the HEAL Program——

Mr. **Kostmayer**. Are you eligible for HPSL?

Mr. **Morales**. No.

I talked to several medical students, and I asked them what they would do without the HEAL Program, and the majority said they would not be in medical school.

Mr. **Kostmayer**. Just to interrupt—Dr. Graham indicated you will do relatively well after graduation. Banks know that. Why wouldn't banks loan you the money knowing you would be in a position to pay it back?

Mr. **Morales**. I don't quite understand why banks—maybe because of the high default rates they are skeptical about making such loans to us. Another thing, our school principally puts out primary care physicians. Primary care physicians' incomes are not necessarily that high initially and have a very difficult time paying back their debts.

Mr. **Kostmayer**. We give you some time. There is an intervening period before you need to begin paying the debt back.

Mr. **Morales**. That is true. However, in my particular case, since most of our students do plan to service rural communities the overhead cost which they have to incur and the type of community and the people we are dealing with they don't expect too high of an income.

Mr. **Kostmayer**. Well, if you serve in an underserved area you can get even more of your tuition from the government, isn't that right, under the public health service?

Mr. **Morales**. Yes. There are programs.

Mr. **Kostmayer**. Mr. Behringer, let me ask you how successful your centers have been in working with medical schools to try to refocus educational priorities to primary care and also to offer rotations at rural and community health centers. Can more be done in that area?

Mr. Behringer. A great deal more can be done, and some of the recommendations which we brought before you will list some of our ideas in that area. It is not consistent across the country. It is not consistent, even, among the different departments within the medical schools themselves.

I think the emphasis we have is not only helping the medical schools to identify and attract those individuals who potentially would go into primary care upon their admission to the school but also those individuals who then would select to work in underserved areas in the long run. Those are very special individuals and, given all of the demands and all of the difficulties that people would have going through medical school which may be oriented away from primary care, I think those are the folks that need the support that those role models—that title VII basically provides them, and we would like to play a larger role with the community in migrant health centers and rural areas for providing those role models.

Mr. Kostmayer. Dr. Graham, let me ask in conclusion, given your experience, your opinion why this country has not dealt in a better way with the health care crisis, its affordability, its accessibility.

Mr. Graham. One is tempted to say I don't think we have taken it that seriously yet. It is an extremely complicated system, and individual needs are highly variable. For the majority of our population insurance is generally adequate and health services are good. It is still the one place in the world that you might wish to come if you were seriously ill. So we don't have a health system, we have multiple health systems, and how the system deals with you depends upon your personal, geographic, ethnic and economic circumstances.

And the—if I could finish the thought—the changes that are now being discussed will require a high degree of consensus on the part of the Congress, the administration and the public. And you asked my personal opinion, and my personal opinion is there have been so many different perceptions that consensus has never been able to be forged.

Mr. Kostmayer. Who doesn't share that consensus?

Mr. Graham. I would suspect it would be impossible at the present time for the members of this committee to report out a consensus bill dealing with health services access in the United States.

Mr. Kostmayer. Do you think the American people have reached a consensus?

Mr. Graham. Absolutely not.

Mr. Kostmayer. Your favorable comments about our system did not speak to the cost, specifically, the collective national cost which is extraordinary and rising quite rapidly.

Mr. Graham. And some believe that that is a problem, and you will still find in the literature some who argue there is no magic right or wrong level of GNP. I feel I have given you a superficial answer to a difficult question.

Mr. **Kostmayer**. Thank all of the witnesses. Adjourned until 1 o'clock p.m.

[Whereupon, at 12:45 p.m. the subcommittee recessed, to reconvene at 1 p.m. the same day.]

[Brief recess.]

Mr. **Bruce** [presiding]. Good afternoon. Welcome to the committee. We are happy to have our nursing panel. They will address reauthorization of title VIII.

Before introducing this panel, I would like to again recognize the recent complement of the nursing training programs requested by this committee from HHS in the last reauthorization. This independent evaluation highlights the value and success of many title VIII programs and suggests if anything they should receive more resources instead of being cut as the administration is suggesting.

I ask a copy of the Executive summary of this report be made part of the record.

[Testimony resumes on p. 155.]

[The information follows:]

DRAFT

FINAL REPORT

EVALUATION OF NURSING EDUCATION PROJECTS

The Nursing Shortage Reduction and Education Extension Act of 1988 (Title VII of PL 100-607) amended Title VIII (Nurse Education) of the Public Health Service Act to call for biennial evaluations of Title VIII projects. Specifically, Section 859 states:

> (a) The Secretary shall, directly or through contracts with public and private entities, provide for evaluations of projects carried out pursuant to this title and for the dissemination of information developed as a result of such projects. Such evaluations shall include an evaluation of the effectiveness of such projects in increasing the recruitment and retention of nurses.
>
> (b) (1) The Secretary shall, not later than January 10, 1989, submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the senate, a report describing the manner in which the Secretary intends to carry out subsection (a).
>
> (2) The Secretary shall, not later than January 10, 1991, and biannually thereafter, submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report summarizing evaluations carried out pursuant to subsection (a) during the preceding two fiscal years.
>
> (c) of the amounts appropriated each fiscal year to carry out this title, the Secretary shall make available one percent to carry out this section.

Provisions of Title VIII

Title VIII of the Public Health Service Act provides nursing education support through financing educational program innovation, development, and maintenance; and graduate and undergraduate student grants, loans, and scholarships. Approximately $290 million was appropriated for these programs in FYs 1985 through 1989, the focal years of this report.

Title VIII contains eight distinct programs, four that provide program support to nursing schools and other institutions and four that provide support to graduate and undergraduate nursing students. One of the institutional support programs, Special Projects, currently has ten subcomponents, each addressing a different purpose for which grants might be made. These purposes have changed over time as national priorities and health care needs have evolved In FY 1989, 552 program grant awards were made under Title VIII; 163 nursing schools received undergraduate scholarship awards, and 529 schools participated in the Nursing Student Loan program.

Evaluation Method

In accordance with Section 859(b)(1), a report dated February 1989 on the plans for carrying out the first evaluation of the Title VIII projects was submitted to the Congress. The plan indicated that all areas of the current provisions of Title VIII would be addressed within the overall evaluation scheme. However, the programs under Title VIII would be classified according to whether: (1) a history of completed project activities was available to form the basis for evaluation; or (2) the program had been newly established and only recently funded. The latter group of programs would be described and, to the extent of information available, the level of interest and the type of grants issued would be identified.

Dissemination of the findings has always been an expected activity of each grant. Throughout the administration of Title VIII, it was anticipated that grantees would disseminate and make available information about project outcomes and findings. The evaluation process, therefore, included a review of dissemination activities and the effectiveness of these activities in making the findings available to others who would benefit from the knowledge.

To implement the evaluation plan, which would be used for the development of the 1991 report, the decision was made to select a single contractor with overall responsibility for the evaluation of each of the programs. This approach guaranteed a uniform methodological design with standardization of goals and objectives; and ensured that cross-cutting issues within and among the varied programs would be incorporated in the review.

Two steps were taken to ensure that the evaluation would incorporate broad concerns of those with an interest in the nursing community. Prior to the initiation of a contract, the Advisory Council on Nurses Education provided recommendations of issues and Title VIII areas for incorporation in the evaluation plan. The Advisory Council on Nurses Education is a statutory body appointed by the Secretary in accordance with requirements in Title VIII. In addition, in accordance with the contract requirements, the contractor appointed a group of individuals knowledgeable and experienced in the areas of evaluation research, nursing education and service, and health care system organization to provide technical guidance during the course of the contract.

As a result of the competitive award process, Levine Associates, Inc. was selected as the contractor to carry out the evaluation study which is summarized in this report. This evaluation of Title VIII programs focused on the following major issues:

- How and to what extent have the programs facilitated the removal of financial barriers to a nursing education?
- How and to what extent have the programs promoted the role of nurses as health care providers?
- How and to what degree have the programs achieved the specific purposes delineated in the legislation?
- How and to what extent have grantees disseminated findings from completed grant activities and made those findings available to those who could benefit from them?
- How effective have these programs been in increasing recruitment into nursing?
- How effective have these programs been in increasing the retention of nurses in the profession?

Each question was applied to the legislation as a whole and to each Title VIII program to which it was relevant.

These questions provided the framework for obtaining, organizing, and analyzing information data sources. Detailed sub-questions tailored to each program and purpose of Title VIII were used to guide data collection and analysis.

A sample of 166 grants was selected for study from among the more than 800 awarded in fiscal years 1985-1989. Exclusive of the student loan and scholarship programs, the sample grants involved 44 separate institutions, many of which had several grants, usually under different sections of Title VIII.

The primary source of data on the grants selected for study came from the grant files which contained initial proposals, staff and reviewer notes, and official progress and final reports. Follow-up site visits and telephone interviews were used to supplement this information where necessary.

Conclusions

The conclusions reported are those drawn by the contractor looking only at the impacts of Title VIII programs without reference to other competing priorities. As such they do not necessarily represent the views of the Department or the Health Resources and Services Administration.

Levine Associates, Inc. came to the following overall conclusions in their evaluation of the Title VIII programs. The brief summary included here has been organized around the six major evaluation questions and the individual program areas. A full discussion of the findings and the conclusions is included in the Levine Associates Final Report: Evaluation of Nursing Education Projects appended to this Executive Summary.

Removal of financial barriers to nursing education

- Nursing student support does aid needy students', promote more rapid degree completion, and, probably, attract some people into nursing. However, given the large number of nursing students, the support is too limited to have substantial and measurable effects on this number.

- The rapid advance of graduate nursing education in scope,, quality, and accessibility is mostly due to Title VIII programs. Without these, sources of high quality graduate nursing education would, if available, be very limited.

Promoting the role of nurses

- Federal support plays a key role in promoting and supporting innovations in nursing education that respond to the national need for more cost-effective health care and to key issues such as aging, health care underservice, and rapidly changing health care technology and skill requirements. This support has also expanded opportunities to provide care to the underserved through innovative nurse-managed clinics, birthing centers, and community programs.

- Advanced degree nurses graduated from Title VIII projects are role models who provide education and leadership in response to changing health needs.

Achievement or legislative purposes

- The short-term objectives of the grants were generally met. Most projects were designed and implemented, met their enrollment goals, and produced graduates. A few had problems which generally centered on recruiting suitable faculty, students, skilled preceptors and developing needed linkages with clinical facilities.

- The long-term objectives of Title VIII, such as increasing retention and recruitment, and career development for employed nurses were not systematically measured by the grantees. On-going data collection on these issues is vital to their effective evaluation.

Dissemination

- Dissemination of project findings and methods by grantees has been excellent and varied. For example, with regard to Special Project grants, products, such as audio-visual learning modules, were identified in the contract review. The benefits of Title VIII have been greatly expanded by the activities. These activities take place in addition to such activities as the inclusion of grant findings in Federal presentations, in Congressional reports and as part of the informational material supplied to the Congress.

Recruitment into nursing

- Federal funding, especially of Special Projects and advanced nurse training, promotes recognition of nursing as essential to assuring high quality health care, provides nursing role models for non-nurses, and facilitates access to advanced education and career mobility, thus helping to stimulate recruitment into nursing.
- Federal student financing is probably too limited to have a substantial effect on recruitment.
- special projects for the disadvantaged probably have a positive indirect effect through the development of innovative teaching methods and their dissemination. However, they are too few to have a significant direct effect on the numbers of students recruited.

Retention of nurses in the profession

- Federal funding, especially of special projects and advanced nurse training, promotes recognition of nursing, and facilitates access to advanced education and career mobility, and thus helps promote retention in nursing.
- Advanced Nurse Education grants encouraged part-time graduate school enrollment, thereby increasing the accessibility of graduate nursing education programs, which resulted in an expansion in the number of nurses with advanced skills and enhanced professional roles, both of which are factors that are often vital to retention in nursing.

Other

- This evaluation demonstrated a pressing need for on-going data collection on the long-term retention effects of Title VIII as reflected in graduate career patterns.
- The interaction of multiple grant awards at some nursing schools strengthens the outcomes of the individual grants and strengthens the schools and their faculties.

Findings for Individual Programs

- Special Project Grants and Contracts

  This section is intended to improve nursing practice by increasing the knowledge and skills of nurses and to reduce nursing vacancies and turnover. Sixty-one (61) of the 350 fiscal year 1985 through 1989 grants under the 10 purposes of the section were evaluated. The grants were especially effective in enhancing the role of nurses as health care providers to underserved populations and in disseminating findings. They were also very successful in meeting their specific legislative objectives. Less clear was the impact of the grants on retention in the profession. more time is needed to observe this effect than was available to the evaluation.

  The impact of Special Project Grants is far-reaching because the grants' products are constantly used and continue to reach large numbers of nurses and its innovations are widely replicated. Curriculum materials developed in continuing education projects are frequently incorporated into formal nursing education programs.

- Advanced Nurse Education

  This section of Title VIII assists collegiate nursing schools to increase the supplies of well-prepared nurse educators, administrators, clinical specialists, and researchers. Over two thirds of the 46 sample grants in this program met or exceeded their performance and legislative objectives.

  Advanced Nurse Education grants promoted the roles of nurses as health care providers. Graduate students and faculty provided models of practice for other nurses and improved the public's and the health professions' perception of nursing. It is widely asserted and has been shown that advanced education increases autonomy and job satisfaction leading to professional stability.

Project director and graduate student interviewees verified that graduate programs provide a way for staff nurses and first-line nurse managers to increase their job satisfaction by preparing for leadership positions in clinical practice, administration, education, and research. The project directors interviewed were convinced that almost all graduates remain in nursing and usually in the advanced practice specialties they studied.

Without the advanced nurse education program, it would have been impossible to begin many new master's and doctoral programs or to expand those already in existence significantly. Further, the effects of the program were often multiplied by supplementary non-Federal funds.

Overall, there was a clear sense that it was the Title VIII awards that facilitated development and implementation of advanced nurse education programs. These programs increased accessibility to master's degree specialty tracks and doctoral programs. many interviewees credited the programs with helping to increase the nation's supply of nurses with advanced education, especially by encouraging part-time graduate study.

- Nurse Practitioner/Nurse Midwife

  This program helps eligible institutions meet the costs of educating nurse practitioners and nurse midwives to deliver primary health care in the home, in ambulatory care, and in institutional settings. The sample included 28 grants in this category, 21 for nurse-practitioner and 7 for nurse-midwifery programs. Program faculty members cited many accomplishments in promoting the role of nursing and in gaining community acceptance for these specialty health care providers. However, appreciation of their potential value sometimes developed slowly and obstacles had to be overcome, such as the difficulty nurse-midwives had in the mid-1980s in obtaining liability insurance.

  Every nurse practitioner and nurse midwifery program studied maintained some clinical sites in medically underserved areas and provided primary care to medically underserved populations. Beneficiaries of these services included migrant farm workers, the homeless and the indigent.

The grants provided the overwhelming majority of funds for program development, expansion and enhancement at the sample schools, many of which were able to capitalize on Federal funding to obtain increased support from their universities and states as well as from private sources such as foundations. A recurring theme among the grantees was that most sample programs could not have started or maintained operations without Federal support.

Dissemination of information about experiences in initiating, developing, and managing these programs was widespread.

The programs that conducted alumni surveys reported that a great majority of graduates are active in their specialties. Many worked in underserved areas and in public health and outpatient settings where they provided effective care to the needy at moderate cost. However, despite their documented strengths as cost-effective health care providers, nurse practitioners and nurse midwives were not used to their fullest potential. Professional,legal, and reimbursement barriers restricted their practice somewhat.

- Nursing Education Opportunities for Individuals from Disadvantaged Backgrounds

Eight of the 27 grants which supported projects related to individuals from disadvantaged backgrounds during FY 1985-1989 were studied. They focused on disadvantaged students from inner cities, rural areas and Indian communities.

A recurrent theme among the projects studied was that assistance to disadvantaged students is very resource intensive and costly.

Directors of these projects provided convincing evidence that the program facilitated recruiting disadvantaged students into nursing; that large proportions of aided students completed their studies and entered the nursing profession; and that many student participants would have been unable to study without project support. The successes of these projects stemmed both from the financial aid and from the special educational services, including remediation, teaching aids, and tutorials, they provided.

This program's student stipends, even when in amounts less than what was needed, had a significant impact on successful studies completion by disadvantaged students. There is little doubt that many of these students would not have been able to complete their education without this program's financial and educational assistance.

While most of these projects provided evidence that their objectives were achieved, there was a lack of consistent data on recruitment, student retention and licensure outcomes. Programs that monitored progress reported high retention rates among students who received support. Dissemination of the findings has been widespread thus increasing the program's benefits.

- Professional Nurse Traineeships

Funds for traineeships are awarded to support students in master's and doctoral programs. While funding has been stable for more than a decade, graduate enrollment has increased more than four-fold since the early 1970s. Thus traineeships now average about $1,000. Beginning in 1989, half-time students were included in the program with 25 percent of available funds set aside for their support. Of the 200 nursing schools aided by traineeship program, 32 were in the study sample. Tuition alone often greatly exceeded the value of a traineeship at these schools. Overall, though this support was widely valued, it had marginal effects on recruitment into graduate nursing education and on retention in nursing. Traineeships did allow some students to change from part-time to full-time status and thus accelerated degree completion and return to the job market.

Although data on trainee post-graduation work experiences were not often available, one school that conducted a survey reported that 90 percent of its master's degree graduates were employed full-time in nursing specialties. Another school reported that 95 percent of its master's graduates had positions in their fields of study.

Overall, traineeship funds facilitated completion of graduate programs. This allowed graduates to enter into higher positions in nursing administration, education, and practice, the types of position in which retention in the profession is particularly high.

Much anecdotal information on alumni activities was collected during interviews. It largely validates the widely held view that nurses who invest time and money acquiring advanced degrees do work in their fields of study.

- Post-Baccalaureate Faculty Fellowships

  First implemented in FY 1987, this program supported faculty research on innovative nursing interventions addressing national priorities such as cost-effective health care delivery models for the elderly, premature infants, and other high risk populations. In fiscal years 1987-1989, 229 one-year fellowships were awarded. Some grantees reported that the funding was inadequate considering the work required to secure it. Recipients often reported that the program's tuition, fee and stipend allowances did not meet the costs of obtaining an advanced degree and the one-year support period was too short for doctoral research. Over 90 percent of the recipients sampled reported that they have or will become tenured faculty members in their specialties after completing their degrees.

- Nursing Student Loans

  This section authorizes loans to financially needy full and half-time undergraduate and graduate nursing students. Loans are limited to $2,500 for each of the first two years and $4,000 each for two later years of study with a lifetime ceiling of $13,000. Loan repayment is made over a period not to exceed ten years beginning 9 months after graduation. The law authorizes the Secretary of Health & Human Services, subject to the availability of funds, to repay up to 85 percent of a loan, including interest for post-graduation employment in health care settings such as public hospitals and community health centers. These partial loan repayment provisions of the law were suspended from FY 1984-FY 1989 due to lack of appropriations. The FY 1990 appropriation was $1,000,000.

  Less than a third of nursing programs participated in Nursing Student Loans, there were fewer than 13,000 borrowers each year, and the average loan amount was approximately $800. Even where available, the loans were rarely a major education financing resource. Several sample schools with large numbers of needy students, though, found it very valuable. Also, when combined with other types of financial aid, these loans undoubtedly enabled some students to pursue a nursing education.

- Undergraduate Scholarships

  This section was added to Title VIII in 1988 to make tuition and fee scholarships available to financially needy nursing students. Recipients must sign an agreement with the Secretary of Health & Human Services to serve for not less than two years after graduation in facilities such as public hospitals and Medicare/Medicaid provider institutions. The program disbursed an initial $1.24 million in scholarships to 167 nursing schools in FY 1989, an amount sufficient for fewer than 400 scholarships.

It is too early to determine the impacts on recruitment into nursing. However, it is doubtful that it increased recruitment very much by removing financial barriers since the scholarship awards were limited to tuition and fees and since few scholarships were awarded. Nevertheless, they did give significant financial help to some students, including a number who would not have stayed in nursing school without this aid. They clearly have value as part of the financial aid resource pool which, as a whole, plays a major role in recruitment into nursing.

Summary

This report provides the findings of the first of the evaluation studies required under Section *859(a) of Title VIII of the Public Health Service Act. It provides an overview of how and to what extent the grants carried out under each of the Title VIII sections have met their own and the legislative objectives.

As indicated in the summary of the contractor's findings reported in this Executive Summary and in the attached full report of the study, there are large numbers of nursing educational programs and students. The funds available for any one program would be insufficient to make significant changes in these overall numbers. Thus, the ability to measure impact and effectiveness on an aggregate basis is diminished. Furthermore, since the review was confined primarily to activities occurring during the life of the grants or shortly thereafter, the long-term impacts could not be measured. Therefore, the next phase of the evaluation will focus on whether the project activities have been maintained after funding ceased. It will also evaluate the retention of the graduates who were products of the various funding sources and the contributions of these nurses to the enhancement of health care delivery.

Mr. **Bruce**. I notice the presence of a colleague, Mr. Dymally. Mr. Dymally, we would be happy to entertain a statement from you before we begin this panel.

Mr. **Dymally**. Very brief.

Mr. **Bruce**. We would be happy to entertain it. If it is not objectionable to you to take the chair at the end of that table next to that microphone. Happy to have a member from California here. Mr. Dymally is here from the Education Committee.

STATEMENT OF HON. MERVYN M. DYMALLY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. **Dymally**. Thank you very much Mr. Chairman, and I thank the panel for permitting me to rudely interrupt testimony. I have a Foreign Affairs Committee meeting at 1:30, and I am involved in the official writeup of the bill. I have a statement I would like to enter into the record, with your permission.

Mr. **Bruce**. Without objection.

Mr. **Dymally**. This is a question about discrimination against foreign medical graduates. It is not an entirely new issue to me. I have spent a lot of time on this issue since I have been in Congress. I have flown from Los Angeles to Sacramento to appear before what is called the Medical Quality Assurance Board. It is a kind of State board for medical practitioners to deal with a number of problems foreign graduates have and the requirements that States ask of them, such as requirements which involved getting letters from a dean who is dead, or going back to school to find out how many volumes are in the library and finding the school is closed. These are the contradictory types of requirements put on these graduates.

And so what we are proposing is to set up an advisory committee that would work with the Medical Association. And, to their credit Mr. Chairman, even though they may not be formally endorsed in this bill, the medical association is working on the problem and trying to deal with a number of issues foreign medical graduates have raised.

One of the problems, in the AMA is they don't have a forum for foreign medical graduates. They have been most sensitive to this issue, and they are working on it. I trust that we could rule very favorably on this piece of legislation to solve what is a critical need, especially in the inner cities where we need more doctors.

I think statistical studies will show there are probably a surplus of doctors in certain parts of the country, but when you look into the underserved ghettos, barrios and rural areas there is still a critical shortage of doctors.

I thank you for the opportunity to testify.

Mr. **Bruce**. I thank Mr. Dymally for his testimony. I served on the Education Committee with him in the 1985 and 1987 period and know of his interest. This goes back a long way, including his service as Lieutenant Governor of California.

Mr. **Dymally**. I thank the panelists for permitting me to interrupt.

[The prepared statement of Mr. Dymally follows:]

PREPARED STATEMENT OF HON. MERVYN M. DYMALLY

Mr. Chairman, thank you for the opportunity to be here before you today.

I have introduced legislation, along with my distinguished colleague, Mr. Towns, to end the broad discrimination that International Medical Graduates [IMGs] experience in medical licensure and practice. H.R. 319, the International Medical Graduates Anti-Discrimination Act, would eliminate the discrepancies in medical licensure requirements between domestic and International Medical Graduates.

Approximately 123,000 of our Nation's 569,000 physicians are International Medical Graduates. These physicians serve primarily in underserved urban areas. They are a valuable resource to the health care of our Nation. Despite studies that have demonstrated that IMGs are comparable in medical knowledge and clinical skills to their domestically educated counterparts and while we rely heavily on their services, they are subjected to dual medical licensing standards and discrimination in both overt and covert forms.

The legislation I have introduced with Mr. Towns is a response to both a recent GAO report on medical licensure, which was requested as part of the last title VII reauthorization, and the hearing held by this subcommittee during the last health professions reauthorization which clearly demonstrated that IMGs are subject to discrimination in three categories: residency programs, licensure and employment. My bill will not lower medical licensure standards and it will not create Federal Government infringement on the States' role in medical licensure. My bill will eliminate the two-tiered system of medical licensure.

My bill has three major components. First, it will eliminate the differences in medical licensure and licensure by endorsement requirements between domestic and International Medical Graduates. These differences, including additional years of residency requirements for IMGs, are clearly discriminatory. The measure would also provide equal access to IMGs in jobs, hospital promotion and other employment related matters.

Second, my bill would establish an HHS Advisory Council to make recommendations on the progress of the now developing AMA National Physician Credentials Verification Service. Involvement by the Secretary of Health and Human Services is necessary in order to ensure fairness in the operation and implementation of such a service. This new repository will expedite the licensure process for practicing IMGs who often experience interminable delays when they apply for licensure in a second state. The AMA is to be commended for this initiative but it must be recognized that their program lacks a forum for IMGs to express their concerns as this new program begins.

Third, this legislation would make it unlawful for a residency training program to deny a residency slot to an IMG purely on the basis of the location of their medical school. Testimony received by the Senate Labor and Human Resources Committee last year clearly demonstrated that many residency programs will not even look at an application from an IMG. At a time when the maldistribution of physicians is of increasing concern and health care costs are rapidly increasing as a percentage of GNP, it is essential that such a discriminatory practice be made illegal.

Finally, my bill will require the Secretary to obtain data which was missing from last year's GAO report, such as information from the States on the processing of applications for licensure and residency training. The measure also authorizes funding for the new United States Medical Licensing Exam. This new single examination pathway to licensure will be administered to all medical licensure applicants.

Mr. Chairman, my goal is to eliminate discrimination toward International Medical Graduates. I hope that I am able to work with you and others on the subcommittee, including Mr. Towns and Mr. Richardson, as your subcommittee reauthorizes the Health Professions Act.

Thank you Mr. Chairman.

Mr. BRUCE. We are happy to have this panel here, and we have already entered into the record a very good evaluation done by Health and Human Services on that particular title.

Our first witness is Allison Kozeliski, education coordinator at Rehoboth-McKinley Christian Hospital, Gallup, N. Mex.; followed by Rita Carty, president of the American Association of Colleges of Nursing; and followed then by Deborah Bash, director of the Georgetown University Graduate Program in Nurse Midwifery; Jan Towers, director of government affairs, American Academy of

Nurse Practitioners; and Lorraine Jordan, director of education and research for American Nurse Anesthetists.

I am happy to have this panel here. We will begin with Ms. Kozeliski.

STATEMENTS OF ALLISON KOZELISKI, ON BEHALF OF NEW MEXICO NURSES ASSOCIATION AND AMERICAN NURSES' ASSOCIATION; RITA M. CARTY, PRESIDENT, AMERICAN ASSOCIATION OF COLLEGES OF NURSING; DEBORAH M. BASH, ON BEHALF OF AMERICAN COLLEGE OF NURSE-MIDWIVES; JAN TOWERS, ON BEHALF OF AMERICAN ACADEMY OF NURSE PRACTITIONERS; LORRAINE JORDAN, DIRECTOR, EDUCATION AND RESEARCH, AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Ms. **Kozeliski**. Thank you.

Mr. Chairman, my name is Allison Kozeliski, RN. I am representing the New Mexico Nurses Association, 1 of 53 State and territorial members of the American Nurses Association. I am a registered nurse at Rehoboth-McKinley Christian Hospital in Gallup, N. Mex.

I am pleased to have this opportunity to thank you and the committee for your past support of nursing education and to describe our view of the Nation's need for reauthorization of the Nurse Education Act [NEA].

I would like to speak first about the nursing shortage. We have recent Federal data that indicates that the supply of registered nurses in the workforce is larger than ever before. Despite the improvement in the actual supply of RN's, our Nation continues to experience its most prolonged nursing shortage. The demand for RN's is overwhelming.

For example, despite powerful incentives to make hospitals labor-efficient and keep down the number of hospital employees, from 1977 to 1988 the number of RN fulltime equivalents per 100 hospital patients actually increased from 61.7 RN to 98 RN FTE's per 100 hospital patients. In the nonhospital setting, there is also a dramatically increased intensity of nursing care needs.

Mr. Chairman, despite strong disincentives to hire employees in this era of cost containment, RN's are clearly essential to efficient, high quality and highly productive performance of organized health care.

I would like to give a picture of New Mexico's health care needs. Our rural, sparsely populated State has 14 basic nursing education programs operating at capacity. Right now, New Mexico has a total of 9,180 RN's. Only Idaho and Louisiana have a lower number of RN's-to-total population. New Mexico designated 30 out of all 33 counties in the State as experiencing a severe nursing shortage. New Mexico also has identified 30 of 33 counties as experiencing a critical shortage of primary health care providers.

If we are to continue to meet our State's primary health care needs, we must have continued support from the NEA to sustain our one existing nurse practitioner program and develop new nurse practitioner/certified nurse midwife programs.

I would like to describe New Mexico's experience with the NEA. I am pleased to report that New Mexico has received support from several key program areas of the NEA. For example, students in our State's one master's degree program receive support from the Professional Nurse Traineeship Program of the NEA. There are two Special Projects Program awards in the State, one for a Geriatric Education and Health Management Program and one RN to BSN completion project within a county which is approximately 66 percent Native American and 15 percent Hispanic population.

The Undergraduate Scholarships Program of the NEA made awards to 19 New Mexico students in 1990. Our State's only nurse practitioner program, a Family Nurse Practitioner program at the University of New Mexico, Albuquerque, is funded by the NEA. This project recruits students from rural and underserved areas. Of note is New Mexico will receive an award next month from the Disadvantaged Nursing Student Program of the NEA.

Now I would like to talk about recruitment into nursing. The American Nurses Association has made a commitment to the recruitment to nursing of nontraditional students: minorities, second career individuals and older students, for example. Survey research has indicated that nursing students may leave their educational programs with between $10,000 and $13,000 of indebtedness. According to a National Student Nurses Association survey, 17 percent of nursing students indicated that they had to delay their education due to unavailability of funding.

Fortunately, the NEA does provide traineeships and loan repayment in several sections of the Act. We believe the NEA-sponsored student support is assuring access to nursing education, particularly for minority students and for other nontraditional students.

I would like to describe New Mexico's achievements in minority nursing education. We are very pleased with the contract from the NEA Special Projects Program to establish a Hispanic Career Mobility Mode, the RN to Bachelor of Science/Master of Science in Nursing Program. Today, 107 Hispanic nurses are enrolled in the advanced education program and 18 are actually applying for graduate study. Our most recent enrollment data indicate that 181 Hispanic nursing students were admitted to all of the State's nursing programs, as well as 28 Native American nursing students. To date, 6.5 percent of the total master's degrees in nursing enrollment in the State are Hispanic nurses.

Mr. Chairman, the New Mexico Nurses Association understands that a very tight budget year faces us. However, a large number of applications for NEA support were previously approved for funding in the rigorous quality review process of the Division of Nursing, but because of the limited size of the total NEA appropriation, they were not funded and were not implemented. Specifically, in 1990 there were 45 advanced nurse education projects, 29 nurse practitioner/certified nurse midwife projects, 13 projects totaling $1.7 million for individuals from disadvantaged backgrounds, and 11 special projects were approved but unfunded.

Mr. Chairman, we believe your review of the process which administers the NEA will reveal a well run program which provides absolutely critical data collection efforts about nurses and nursing, for the use of the profession and for other national, regional and local health planning purposes.

Mr. Chairman, our Nation must have adequate numbers of well prepared registered nurses in order to meet the health care needs of its citizens. To prepare nurses needed now and in the future, I urge your support for reauthorization of the Nurse Education Act.

Mr. **Bruce**. Thank you, Ms. Kozeliski.

[The prepared statement of Ms. Kozeliski follows:]

Prepared Statement of Allison Kozeliski, on Behalf of American Nurses' Association

Mr. Chairman, I am Allison Kozeliski, RN. I am representing the New Mexico Nurses Association, one of 53 state and territorial members of the American Nurses Association. I am employed as a registered nurse at Rehoboth-McKinley Christian Hospital in Gallup, New Mexico.

The New Mexico Nurses Association and the American Nurses Association are pleased to have this opportunity to describe our view of the nation's need for reauthorization of the Nursing Shortage Reduction and Education Extension Act of 1988, more commonly called the Nurse Education Act [the NEA].

We also wish to thank this committee for its commitment and support of nursing practice and nursing education.

The Nursing Shortage

Recent Federal data indicate that the supply of registered nurses in the work force is larger than ever before. Now, more than ever before, there is a higher percentage of RNs employed in the work force. More than 80 percent work force participation for RNs is exceptional for a predominately female profession, 70 percent of whom are married and 55 percent of whom have children at home.

Despite the improvement in the actual supply of RNs, our nation continues to experience its most prolonged nursing shortage. There are multiple causes of this shortage, but the most significant cause is the demand for RNs, whose flexible, broad base of knowledge is essential in all practice settings where there are health care needs.

For example, hospitals are the employment setting for about two thirds of the nation's nurses. Because of dramatic cost-containment efforts, all hospitals have powerful incentives to keep down the number of hospital employees, in order to make operations as labor-efficient as possible. Despite this powerful economic incentive, the demand for nurses in hospitals has driven upwards the RN-to-patient ratio. In 1977, there were 61.7 RN fulltime equivalents [FTEs] employed per 100 hospital patients. By 1988, that figure had increased to 98 RN FTEs per 100 hospital patients.

This increased demand is due to shorter length of stay and admission criteria which assure that only the very sickest are admitted to the hospital. In the nonhospital setting, there is also an increased intensity of nursing care needs among, for example, those who require home health care, those who require nursing facility care and physically challenged children who are mainstreamed students in our nation's schools.

Mr. Chairman, despite strong economic disincentives to hire employees in this era of cost containment, RNs are clearly essential to efficient, high quality and highly productive performance of organized health care.

Private sector response to the nursing shortage rarely has taken the form of service payback in return for scholarship support for nursing students. The private sector, however, has not provided funding to support educational programs that prepare nurses. For example, hospitals may divert from their nurse recruitment budgets some limited funding for nursing student scholarships or loans that carry an employment payback upon graduation. This practice has not been widespread and may not occur at all among predominately minority hospitals which may not have the budget nor the budget flexibility for this approach. Also, nonhospital employment settings such as nursing facilities, schools, hospice and home health agencies rarely have the budget capacity to provide scholarship support for nursing students.

I emphasize that although some private sources exist for nursing student support, they do not exist in all parts of the country nor do they benefit the nonhospital employment sector; also, they may not be offered in places which benefit minority nurses. I emphasize, also, that basically the only support for nursing education programs comes from the NEA.

New Mexico's Health Care Needs

Our rural, sparsely populated state has only 14 basic nursing education programs, or barely one percent of the nation's nearly 1500 nursing education programs. These programs are performing at capacity to produce the state's supply of registered nurses. The continuing supply of RNs is necessary to meet the state's goals for our citizens' health and quality of life.

Right now, New Mexico has a total of 9,180 RNs. That translates to 415 RNs per 100,000 citizens. Only Idaho and Louisiana have a lower number of RNs-to-total population. The New Mexico nursing shortage was validated by a state initiative to designate counties which were truly affected by the nursing shortage. Thirty out of all 33 counties in the state were designated as experiencing a severe nursing shortage. Noteworthy for nurse practitioners, certified nurse midwives, clinical nurse specialists and other nurses with advanced practice knowledge, New Mexico has also identified 30 of 33 counties as experiencing critical shortages of primary health care providers.

The Seventh Report to Congress (1990) projects that New Mexico will need 10,300 to 13,300 RNs by the year 2000. Our 14 nursing education programs cannot produce that many nurses by the year 2000. If our capacity to produce RNs is to grow and be maintained, our nursing education programs must have continued support of the Nurse Education Act.

Because of the health status of our citizens and other characteristics common to largely rural states, our state has unmet health care needs. New Mexico needs RNs to meet health care needs of a largely rural population which, compared to urban populations, has a greater incidence of: poverty, very young and very old citizens, medically uninsured and underinsured individuals and also, in general, has greater morbidity and mortality.

RNs are needed in nonhospital settings, as well. There, nurses provide primary care, community-based care, administer and manage nursing operations and teach in schools of nursing. Nurses who perform these functions are prepared at the master's degree level. There is only one graduate nursing program in New Mexico. This program prepares family nurse practitioners and nurse expert clinicians and leaders for the state. This Committee is well aware of the contributions to the nation's health made by nurse practitioners and certified nurse midwives. Indeed, we are thankful for your past support of these providers. In one recent study of nurse practitioners, 76 percent of patients seen by NPs in rural areas and 58 percent of those seen in urban areas had family incomes of less than $16,000. The Office of Technology Assessment report: Health in Rural America indicated that minority women were more likely than nonminority women in urban and rural areas to have had a nonphysician provider for their primary care. (p. 390) If we are to meet our state's primary health care needs, we must have continued support from the NEA to sustain existing and develop new nurse practitioner/certified nurse midwife programs.

Current NEA-Support in New Mexico

Mr. Chairman, I've provided a brief picture of needs in our state which are being met by registered nurses. I would like to describe how the current NEA is meeting the nursing needs of our state.

I am pleased to report that New Mexico has received support from several key program areas of the NEA. For example:

Professional Nurse Traineeship (Section 830 of the NEA). The University of New Mexico at Albuquerque is the state's only master's degree program. Currently, UMN, Albuquerque does receive funds to support graduate students in nursing.

Special Projects (Section 820 of the NEA). (1) UNM, Albuquerque, Geriatric Education and Health Management Program. This projects includes a nursing clinic staffed by nursing faculty in consultation with the College of Pharmacy and the School of Medicine. Students provide disadvantaged elderly clients with assessment, diagnosis, planning and intervention to promote health and prevent illness. Baccalaureate of Science in Nursing [BSN] students are assigned to specific client families concurrently with academic courses. Long term care is addressed through inpatient and home health care, as well as in interdisciplinary planning for topical and case-oriented educational conferences at the long term care facilities.

(2) UNM, Albuquerque, RN-ESN Completion Program. The UNM, Gallup campus in western New Mexico is an area which has high morbidity and high mortality, as well as large numbers of two ethnic populations: Native American (approximately 66 percent of county population) and Hispanic (14 percent of the county). This project will improve distribution of BSN nurses, and increase the numbers of nurses who can assume increasingly responsible positions.

Undergraduate Scholarships (Section 843 of the NEA). There were 19 awards, 16 at the associate degree level and three at the bachelor's degree level in Roswell, Las Cruces, Espanola and Albuquerque.

Nurse Practitioner/Certified Nurse Midwife Programs (Section 827 of the NEA). UNM, Albuquerque, Family Nurse Practitioner Program. This project establishes a family nurse practitioner program at the master'sdegree level, recruiting students from rural and underserved areas. The project also develops internship sites in rural and underserved areas, along with outreach of concurrent courses so that students in the final semester of the program can be returned to their home communities. The project increases services to some clinical sites, especially those with health promotion and family education content.

Disadvantaged Nursing Students (Section 827 of the NEA). One project will be funded in June, 1991. Since this is a new award and not yet ready for public dissemination, it will not be known for a few weeks how many students this will benefit.

There have been no awards in New Mexico under the Nurse Anesthetist Program or, at present, the Advanced Nurse Training program of the current Nurse Education Act.

The New Mexico experience at the present time with the Nursing Education Act has been fruitful. We hope the future will hold continued Federal funding for nursing education.

Nurse Faculty and Nursing Student Recruitment

It is not only New Mexico which is experiencing a shortage of qualified faculty to teach in nursing schools. In 1990, one national survey revealed 2,300 qualified students who were denied admission to nursing programs because of a lack of nursing faculty to teach. That survey may have underreported the extent of nursing faculty shortage since the Louisiana State Board of Nursing, alone, reports 1125 qualified students turned away from Louisiana schools of nursing, most of them due to lack of faculty.

For the first time in many years, the nation's graduate nursing programs showed a reduction in the number of full time students enrolled. This may have a significant impact on the supply of future nurse faculty.

The American Nurses Association has made a serious commitment to the recruitment to nursing of nontraditional students: minorities, second career individuals and older students, for example. Survey research has indicated that nursing students may leave their educational programs with between $10,000 and $13,000 of indebtedness. In terms of after-tax earned income, this debt would require between 10 percent to 12 percent of pretax earnings to repay the indebtedness over a five year period.

Expressed in other terms, more than 60 percent of undergraduate nursing students, 68 percent of master's degree nursing students and 58 percent of doctoral students in nursing applied for financial aid. Noteworthy is that only 48 percent received it. According to a National Student Nurses Association survey, 17 percent of nursing students indicated that they had to delay their education due to unavailability of funding.

Fortunately, the NEA does provide traineeships and loan repayment in section 831, Nurse Anesthetist Program, as well as in the undergraduate scholarship program, the disadvantaged student program and the professional nurse traineeship program described above. We believe the NEA-sponsored student support is assuring access to nursing education for minority students and for other nontraditional students.

New Mexico's Achievements in Minority Nursing Education

The state has been awarded a contract with NEA funds from the Special Projects program to establish a unique project. The project is the Hispanic Career Mobility Model, RN to Bachelor of Science/Master of Science in Nursing Program, based at the UNM, Albuquerque. This is an articulated career mobility model which features flexible educational opportunities for Hispanic nurses. Today, 107 Hispanic nurses are enrolled in the advanced educational program. About 25 of these nurses are interested in further study at the master's level and 18 are actually applying for graduate study.

Of the state's 14 basic RN programs, one is a BSN program and the others are ADN programs. Our most recent enrollment data indicate that 181 Hispanic nursing students were admitted to the state's nursing programs, as well as 28 Native American nursing students. To date, 6.5 percent of the total master's degree in nursing enrollment in the state are Hispanic nurses.

Mr. Chairman, the New Mexico Nurses Association understands that a very tight budget year faces us. Please consider an adequate authorization level for the NEA since a large number of applications were previously approved for funding in the rigorous quality review process of the Division of Nursing. However, because of the limited size of the total NEA appropriation, many of these approved projects were unfunded. Specifically, in 1990 the following projects were approved but unfunded: 11 special projects; 45 advanced nurse education projects; 29 nurse practitioner/certified nurse midwife projects; and 13 projects totalling $1.7 million for individuals from disadvantaged backgrounds.

Mr. Chairman, we hope this sample of information illustrates that the need for Federal support for nursing education continues to be critical. We believe your review of the process which administers the NEA will reveal a well-run program which supplies absolutely critical data collection efforts about nurses and nursing, for the use of the profession and for other national, regional and local health planning purposes. Mr. Chairman, our nation must have adequate numbers of well prepared registered nurses in order to meet the health care needs of its citizens. To prepare nurses needed now and in the future, I urge your support for reauthorization of the Nurse Education Act.

Mr. BRUCE. Ms. Carty.

STATEMENT OF RITA M. CARTY

Ms. CARTY. Good morning, Mr. Chairman and members of the subcommittee. I am Rita Carty, DNSC, RN, dean of the school of nursing at George Mason University in Fairfax, Va., and president of the American Association of Colleges of Nursing [AACN]. This is a summary of our testimony, and I ask that the full statement be included in the hearing record.

AACN represents 420 schools of nursing which offer baccalaureate undergraduate, graduate and continuing education programs at senior colleges and universities across the United States. These schools are dedicated to meeting America's demand for professional nurses trained to cope with an increasingly older population, chronic illnesses and the complexities of modern health care treatments and procedures. AACN is here today to support strongly the reauthorization of the Nurse Education Act.

Only 3 years ago nursing school enrollments were sharply down as more young people rejected nursing careers, and critical shortages existed across the spectrum of nursing services. Today, good news predominates: baccalaureate nursing enrollments for 1990-91 are up. Minorities and second career students increasingly are seeking nursing careers; and nursing shortages, while substantial in some areas and specialties, have begun to moderate. But the need for the NEA remains.

This need is based on a lack of nursing school resources, including faculty shortages, which resulted in at least 2,300 qualified applicants being turned away according to a recent AACN survey. Primary care, particularly in rural and other areas underserved by physicians, is increasingly being supplied by professional nurses, especially those with advanced education, such as nurse practitioners, clinicians and midwives. Demographics suggest that older and chronically ill patients, and growing complexities of care, will require more nurses. The shortage was estimated at 200,000 RN's in 1990.

Minorities suffer disproportionately from many health problems, and nurses, especially nurses from minority communities, will be essential to turning that situation around. Entering baccalaureate nursing students are about 17 percent minority, but Federal support is needed to ensure that those students graduate and enter practice where minorities are underrepresented.

Federal financial assistance is critical for making schools able to offer faculty-intensive nursing education, and to making nursing education a viable choice when students compare nursing with careers which may be more lucrative. Older, often part-time students with family responsibilities and jobs seeking advanced preparation particularly are affected.

The NEA is a program of which this subcommittee can be proud. At a time of cutbacks in State and local support for nursing education, Federal programs and student financial support becomes even more essential to meeting central public health objectives. AACN supports reauthorization of the NEA with only minor, "fine tuning" type changes.

At George Mason University's School of Nursing we have 480 undergraduate and 220 graduate nursing students. Our student body is 20 percent minority. We have an NEA nurse practitioner project with George Washington University focusing on adult and gerontological education with an emphasis on both serving underserved populations and recruiting students from underrepresented groups.

We are awaiting a decision on an NEA special project's application for a fast track LPN to BSN program. We know the market is there for this kind of education, but we would not be able to undertake it without Federal support. Once the program is working, we can mainstream it. Facilitating the implementation of new programs is one of the most important functions of the NEA.

On behalf of my students and school and others all over the country, I want to thank the subcommittee for making the NEA a driving force for innovation and access in nursing education.

The following are AACN's comments on specific NEA sections.

AACN supports the existing flexible, yet focused, language of these important NEA provisions. Advanced nurse education is central to training specialized nurses to meet vital primary care, teaching, research and management needs of the public health system. Without advanced education, faculty would not be there to educate future nurses. Nurse practitioners and nurse midwives would not be there to meet primary care needs—especially of rural and underserved communities. Nurse researchers would not be there to measure cost effectiveness and outcomes to improve the quality of care. And nurse administrators would not be there to ensure efficient management of nursing services. Disadvantaged special projects makes nursing education programs more accessible to disadvantaged and minority students.

To encourage innovative approaches to education, special projects offers multiple bases for awards in rural health, geriatric and long term care, skill upgrades and continuing education, community and institutional demonstration projects.

Specific changes AACN suggests are: Deletion of the subsection which matches students and institutions willing to repay loans [it is not used]; increase flexibility to meet changing primary care needs by eliminating funding set asides.

Professional nurse traineeships supports individuals aspiring to become the advanced practitioners and faculty so much in demand. This is extremely important for students who often are older with family responsibilities and who may be working. The assistance is now limited to nurses, but several schools of nursing offer those from other professions the opportunity to obtain advanced nursing education. To bring these people into nursing, PNT's should be available to anyone in an advanced nursing education program. Also, we suggest revision or deletion of the post baccalaureate faculty fellowships.

Employer loan repayment should be deleted because it has been used by only one student since 1988.

Scholarships for the undergraduate education of professional nurses. Changes AACN would like to see in SUEPN: Program should become fully campus managed, like the Nursing Student Loan Program, clarified eligibility for students with nonnursing degrees and associates degrees if they meet the financial need and disadvantaged standards, and a year-for-year service payback.

In terms of authorization funding levels, there is a strong relationship between NEA funding and nursing enrollments. As funds have gone up or down, enrollments eventually follow. This suggests that stability in funding and programs is extremely important to the continued success of the NEA in meeting the public health need for nursing professionals at all levels of care and service. AACN supports a 10 percent increase in NEA authorization levels rising to $132 million for fiscal year 1994. We would not want to limit funding opportunities in the event that more money becomes available for NEA programs in future fiscal years. In addition, we favor the continued line by line authorization with fixed sums as opposed to lump sum authorization or "such sums."

In conclusion, AACN appreciates being given the opportunity to present to the subcommittee our thoughts on, and support for, the reauthorization of the Nurse Education Act. We would be happy to answer your questions.

Mr. **Bruce**. Thank you, Ms. Carty.

[Testimony resumes on p. 176.]

[The prepared statement of Ms. Carty follows:]

Testimony
of
Rita Carty, DNSc, RN, FAAN
on behalf of
The American Association of Colleges of Nursing

Good morning Mr. Chairman and members of the Subcommittee. I am Rita Carty, DNSc, RN, FAAN, dean of the School of Nursing at George Mason University in Fairfax, Virginia and President of the American Association of Colleges of Nursing [AACN]. AACN represents 420 schools of nursing which offer baccalaureate undergraduate, graduate and continuing education programs at senior colleges and universities across the United States. AACN schools include public and private, secular and sectarian, and large and small institutions dedicated to meeting America's demand for professional nurses trained to cope with an increasingly older population, chronic illnesses and the complexities of modern health care treatments and procedures.

The Need for Reauthorization

AACN strongly supports the reauthorization of the Nurse Education Act [Title VIII of the Public Health Service Act, hereinafter the "NEA"] for AACN. Only three years ago during this subcommittee's last review of the federal role in health professions education, nursing school enrollments were sharply down as more young people rejected nursing careers and critical shortages existed across the spectrum of nursing services. Today, good news predominates:

entry level baccalaureate nursing enrollments for 1990-91 are up 14.3 per cent (after a 5.9 percent increase the previous year); minorities and career change students increasingly are seeking nursing careers; and nursing shortages, while substantial in some areas and specialties, have begun to moderate. But the need for the NEA remains:

* Lack of nursing school resources, including faculty shortages, resulted in at least 2,300 qualified applicants being turned away according to a recent AACN survey. The 44 nursing programs reporting faculty shortages would have needed 123 undergraduate and 39 graduate faculty to admit those applicants.

* Primary care, particularly in rural and other areas underserved by physicians, is increasingly being supplied by professional nurses, especially those with advanced education, such as nurse practitioners, clinicians and midwives.

* Demographics suggest that older and chronically ill patients, and growing complexities of care, will require more nurses. The shortage was estimated at 200,000 RNs in 1990, and a recent American Hospital Association survey showed hospitals with an average 12.6 percent vacancy rate.

- Minorities suffer disproportionately from many health problems, and nurses, especially nurses from minority communities, will be essential to turning that situation around. Entering baccalaureate students are about 17 percent minority, according to a recent AACN survey, but federal support is needed to ensure that those students graduate and enter practice where minorities are underrepresented.

- With other professions open to females who have been the traditional nursing students, federal financial assistance is critical for making schools able to offer faculty-intensive nursing education, and to making nursing education a viable choice when students compare nursing with careers which may be more lucrative. This is particularly true for older, often part-time students with family responsibilities and jobs who seek advanced preparation to become nurse practitioners, midwives, clinicians, managers and faculty.

While the NEA probably isn't solely responsible for all of the positive developments, it certainly has helped and it is a program of which this subcommittee can be proud. At a time of cut backs in state and local support for nursing education, federal program and student financial support becomes even more essential to meeting central public health objectives. AACN supports the reauthorization of the NEA with only minor, "fine tuning" type changes.

The NEA's role at George Mason University's School of Nursing

My school of nursing has 480 undergraduate and 220 graduate nursing students. Our student body is 19 percent minority. We have an NEA nurse practitioner project with George Washington University focussing on adult and gerontological education with an emphasis on both serving underserved populations and recruiting from underrepresented groups. We are awaiting a decision on a special project application for a fast track LPN to BSN program. We know the market is there for this kind of education, but we would not be able to undertake it without federal support. Once the program is working, we can mainstream it. Facilitating the implementation of new programs is one of the most important functions of the NEA. On behalf of my students and school, and others all over the country, I want to thank the subcommittee for making the NEA a driving force for innovation and access in nursing education. The following are AACN's comments on specific NEA sections.

Advanced Nurse Education, Nurse Practitioner/Midwife/Anesthetist, Disadvantaged Special Projects [Sec.827], Loan Repayment [Sec.836]

AACN supports the existing flexible, yet focussed, language of these important NEA provisions. Advanced nurse education is central to training specialized nurses to meet vital primary care, teaching, research and management needs of the public health system. Without advanced education, faculty would not be there to educate future nurses, nurse practitioners and nurse midwives would not be there to meet primary care needs, nurse researchers would not be there to measure cost effectiveness and outcomes to improve quality of care, and nurse administrators would not be there to ensure efficient management of nursing services. Disadvantaged Special Projects makes nursing education programs more accessible to disadvantaged and minority students.

Special Projects [Sec. 820]

To encourage innovative approaches to education, **Special Projects** offers multiple bases for awards in rural health, geriatric and long term care, skill upgrades and continuing education, community and institutional demonstration projects, and matching students with institutions willing to repay their loans. The institutional match provision should be deleted because employers can do this without federal aid. Limiting rural education projects to expensive satellite based systems is unnecessarily restrictive and prevents other, more cost effective approaches. AACN suggests deleting the phrase "through telecommunications via satellite" from Sec. 820(a)(3). And, while Sec. 820's designation of set asides for funds appropriated may accurately reflect the concerns of the Congress at the time of authorization, they reduce the flexibility of the Division of Nursing to focus awards on public health and education priorities years later at the time the funds are actually spent. We urge deletion of the fixed percentage set asides from Special Projects.

Professional Nurse Traineeships [Sec. 830]

Professional Nurse Traineeships support individuals aspiring to become the advanced practitioners and faculty so much in demand. This is extremely important for students who often are older with family responsibilities and who may be working. The assistance is now limited to nurses, but several schools of nursing offer students from other professions the opportunity to obtain advanced nursing education. To open this program up to bring these people in to nursing, PNTs should be available to anyone in an advanced nurse education program. The post baccalaureate faculty fellowships [Sec. 830(b)] have not been popular with schools or students. The subsection should be either revised or deleted. The timing of the awards was a major problem, and the program was not funded in FY 91.

Scholarships for the Undergraduate Education of Professional Nurses [Sec. 843]

The new **SUEPN** program has been successful even though its appropriations typically have been only about ten percent of its authorization. AACN would like to see this program become fully campus managed (like the Nursing Student Loan Program) with the school of nursing institution being responsible for applying for the funds, selecting recipients, making awards, and keeping track of the two year per year of support service requirement, and managing defaults. Also, we would like to see SUEPN eligibility clarified to ensure that students with non-nursing degrees and Associate Degrees are eligible if they meet the financial need and disadvantaged standards. Lastly, this is a tuition and fees only "scholarship" which has a two year service payback for each year of federal support. Other programs with more generous support (National Health Service Corps) have only a year for year service payback, which AACN believes would make SUEPN more attractive to, and fairer for, nursing students.

Employer Loan Repayment [Sec. 847]

With all good intentions, this section sought to connect students with employers who would be willing to repay loans in return for service at the institution. AACN suggests that it be deleted because it has been used by only one student since 1988. Savvy employers already provide tuition reimbursement for employees. A recent American Hospital Association survey found that hospitals offered reimbursement for full time employees for tuition (82.6%) and for continuing education (94.2%), and that part time employees were offered support for tuition by 65.9% of hospitals and continuing education by 88.8%. [1989 Report of Hospital Nursing Personnel Survey, AHA, 1990.] The problems with Sec.847 include the fact that employers do not want to agree to repay the loan of a student they do not know and who may not complete the nursing program, and that employers have to bear the cost of interest on the student's loan.

Other Suggestions

While AACN does not want authorization [or appropriations] for other NEA programs reduced to provide funding for the following, there is a great need for increasing the capability of the Division of Nursing to offer technical assistance [now comes out of program funds], to collect data [Sec. 708 funds are scarce], and to conduct educational research [we need to know what teaching techniques are most effective for various types of students]. In many cases, the beneficiaries of such additional support would be students and institutions with special needs. In addition:

* Evaluations of NEA programs should focus on cost effectiveness and where NEA supported students work after graduation;

* Nursing Student Loan Program monies should remain with the

participating school until either recommitted or the school drops out of the program. Now, after two years, the funds must be returned to DHHS. [Default rates in NSLP (2.30 percent as of June 1990) are among the lowest of any federal loan program.]

* NEA program grant cycles and grant reviews should not be changed without at least 6 months advance notice to avoid disrupting applicant institutional procedures.

* The Division of Nursing should be designated a statutory agency within DHHS to ensure its integrity of mission.

* The Advisory Council on Nurses Education should be renamed the Advisory Council on Nursing Education.

* Nursing schools should be included among the institutions eligible to be prime contractors for Geriatric Education Centers (Sec. 789). Nursing education and the profession focuses strongly on geriatric and gerontological concerns.

Authorization Funding Levels

The attached chart suggests that there is a strong relationship between NEA funding and nursing enrollments. As funds have gone up or down, enrollments eventually follow. This suggests that stability in funding and programs is extremely important to the continued success of the NEA in meeting the public health need for nursing professionals at all levels of care and service. Thus, if the Administration's practice of zero funding the NEA [except for disadvantaged students] were to be endorsed by legislation, precipitous declines in enrollment could be expected.

AACN supports a ten percent increase in NEA authorization levels rising to $132 million for Fiscal Year 1994. We realize that rarely have NEA appropriations approached anywhere near the authorized amount, but the need is there to justify funding increases. We would not want to limit funding opportunities in the event that more money becomes available for NEA programs in future fiscal years. Current funding has forced some schools to spread federal assistance thinly across many students rather than provide adequate help to a few because the need is so great. In addition, we favor the continued line by line authorization with fixed sums as opposed to lump sum authorization or "such sums."

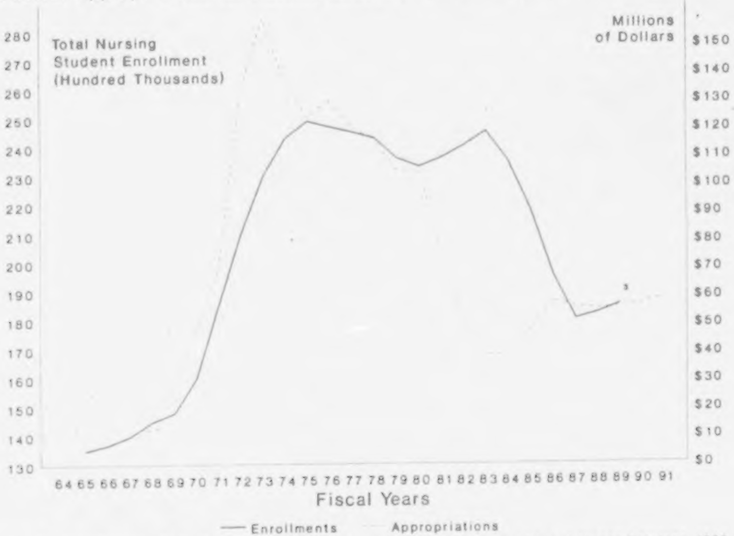
Conclusion

AACN appreciates being given the opportunity to present to the subcommittee our thoughts on, and support for, the reauthorization of the Nurse Education Act. We would be happy to answer your questions.

Attachment NEA530.BH6 5/24/91

ATTACHMENT TO AACN TESTIMONY ON NURSE EDUCATION - NEA REAUTHORIZATION, MAY 30, 1991

Enrollments in All Basic Registered Nursing Programs from 1965-1991[1] and Federal Appropriations for Nursing Education Between Fiscal Years 1964-1991[2]



[1] *Nursing Student Census*, NLN, 1989. [2] Division of Nursing, U.S. Dept. of Health and Human Services, 1990

[3] No data for all basic RN programs for 1990 or 1991 are available, but AACN entering baccalaureate enrollments were up 5.9% for 1990 and 14.5% for 1991, according to a matched sample of 449 schools done by AACN.

NEA530.CHT

Mr. BRUCE. The next witness is Deborah Bash, Director of the Georgetown University Graduate Program in Nurse Midwifery.

STATEMENT OF DEBORAH M. BASH

Ms. BASH. Mr. Chairman, my name is Deborah Bash, CNM, Ed.D.—candidate, and I am a certified nurse midwife and the director of the Georgetown University Graduate Program in nurse midwifery.

It is a pleasure to be here today to speak in support of adequate funding and reauthorization on behalf of the needs of childbearing women in this country, and as a representative of the American College of Nurse Midwives.

The American College of Nurse Midwives is the professional organization for over 4,000 Certified Nurse Midwives [CNM's] in the United States. Nurse midwives are especially proud of their records in caring for pregnant teens in inner cities, mothers in underserved rural areas of the country, Hispanic women in border States, Native Americans on reservations, and minorities seeking care in public clinics.

Nurse midwifery is increasingly viewed as a powerful tool in the effective cost containment and delivery of health care for at risk populations. We all know it is more effective to spend $600 for comprehensive prenatal care for a pregnant woman than to spend $1,000 a day for neonatal intensive care for a low birth-weight baby. Prevention is the most economical plan for our government.

Nurse Midwifery Educational Programs. We must educate nurses today to become nurse midwives of tomorrow. Presently, 30 of America's outstanding colleges and universities educate over 300 nurse midwives annually. A small number when the needs are so great.

Our education programs consist of three types: certified programs, masters programs and doctorate programs and, unlike many other nursing advanced education programs, operate in a variety of settings.

In order to reach a goal of 2,000 new certified nurse midwives by the year 2000, creative educational planning and subsidized programming is a priority.

A new concept in nurse midwifery education is based out of southeastern Kentucky at the Frontier School of Midwifery and Family Nursing. The new program, called the Community Based Nurse Midwifery Education Program [CNEP], has received approximately 4,000 inquiries from nurses around the country since it was announced in 1989. Yes, 4,000. This program is designed to offer greater flexibility in graduate education for self-directed adult learners who prefer independent study or who are unable to relocate to existing nurse midwifery settings.

Another creative means for enrolling large numbers of nurses in nurse midwifery education is to tap the many hundreds of foreign nurses that come to our country, certified as midwives in their country of origin. Presently we have only two foreign refresher programs, one in Kentucky and one in New York. These programs are expensive. The one at the State University of New York Health Science Center at Brooklyn has seven students enrolled this year during its 4 month refresher course. Costs for educating one student is between $19,000 and $21,000, while the cost to the program is $194,000 to run this program. In addition, this tuition is highly subsidized by New York State.

Another unique program links Georgetown University's School of Nursing with the U.S. Air Force program to educate nurse midwives. Six U.S. Air Force nurses are accepted as students annually and receive their theoretical course work at Georgetown University and their clinical experience at Malcomb Grow Hospital, Andrews Air Force Base.

Nurse midwifery education is faculty-intensive and expensive.

Students who represent the pool from which nurse midwifery students are selected are nurses and must have a nursing degree at a baccalaureate level prior to starting nurse midwifery education. This means that many students are in debt from their undergraduate student loans for $20,000 or more before admission to nurse midwifery school. These students will need an additional $18,000 to $43,000 to complete their midwifery education. Prospective students often shy away from these financial obligations when learning that the average midwife's salary was only $36,000 in 1988.

At Georgetown University it costs a full time student nurse midwife approximately $22,000 for tuition and books, not including room and board for 16 months. Students in the full time program cannot work and so they are without income during this period.

According to the latest report from Secretary of Health and Human Services Louis Sullivan, the Nation still has a long way to go to catch up to the rest of the world with regard to reducing infant mortality. Well educated and well prepared nurse midwives can help our Nation meet these needs.

For these reasons, Federal support of nurse midwifery educational programs is vital to the continuation of these programs.

Federal funds to the programs indirectly decrease the tuition costs while the federally sponsored traineeships to students help offset other costs. The Federal funds that you can reauthorize provide incentives to students to enter these nursing programs, especially helping to finance minority students in need of educational stipends.

One of the maternal and infant health objectives set by "Healthy People 2000" is to: "Increase to at least 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy." This objective can be accomplished with Certified Nurse Midwives since early high-quality prenatal care is critical to improving pregnancy outcomes and reducing neonatal mortality.

Present Needs. At this time we are requesting reauthorization levels of 12 percent for each year of the reauthorization. Presently, only nine nurse midwifery programs are being funded. The additional funding requested is only enough to fund four to six additional new nurse midwifery/nurse practitioner programs.

Let me take this opportunity to thank you for hearing my testimony today. On behalf of the American College of Nurse Midwives and the student nurse midwives, I want to thank you for your attention to their educational needs and the ultimate health care needs of the mothers and infants throughout our country.

Mr. BRUCE. Thank you, Ms. Bash.
[The prepared statement of Ms. Bash follows:]

PREPARED STATEMENT OF DEBORAH M. BASH, ON BEHALF OF AMERICAN COLLEGE OF NURSE-MIDWIVES

Mr. Chairman, my name is Deborah M. Bash, CNM, Ed.D. (cand.). I am the Director of the Georgetown University Graduate Program in Nurse-midwifery at the Georgetown University School of Nursing in Washington, D.C. I am pleased to report to the subcommittee on Education on behalf of the American College of Nurse-Midwives [ACNM].

It is a pleasure to speak in support of adequate funding for the Nurse Education Amendments of Title VIII of the Public Health Service Act.

A certified nurse-midwife [CNM] is a registered nurse with advanced education in midwifery who cares for women throughout the life cycle. This care involves the provision of care for women and their newborns not only during pregnancy, childbirth, and the postpartum/neonatal period, but also includes family planning and gynecological services. Certified nurse-midwives work interdependently with physicians with whom they consult and to whom they refer patients who develop complications requiring physician care.

There are approximately 4,000 certified nurse-midwives in the United States. Much of the care of certified nurse-midwives has always been directed at the needs of those women with special problems in accessing childbearing and other health services. Nurse-midwives are especially proud of their records in caring for pregnant women who are at risk for developing health problems because of various social and economic considerations. Pregnant teens in inner cities, young mothers in underserved rural areas of the country, Hispanic women in border states, Native Americans on reservations, and minorities seeking care in public clinics are all clients served by nurse-midwives in daily practice.

The American College of Nurse-Midwives [ACNM] is the professional organization for Certified Nurse-Midwives [CNMs] in the United States. The ACNM is autonomous from other professional organizations and speaks for its membership on all issues affecting the practice, education, legislation, economics of nurse-midwifery, and the clients we serve.

Nurse-Midwifery Educational Programs

Presently, thirty (30) of American's outstanding Colleges and Universities offer the theoretical and clinical course work in midwifery that leads to certification as a nurse-midwife (listing attached). All of these educational programs have been vigorously assessed prior to accreditation by, the ACNM, which is recognized by the U.S. Department of Education. Our education programs comprise three types: certificate programs, masters programs and doctorate programs, and unlike many other advanced nursing education programs, operate in a variety of settings. The thirty nurse-midwifery educational programs educate over 300 nurse-midwives each year.

A new concept in nurse-midwifery education, and one that is trying to increase the numbers of nurses educated to become nurse-midwives, is now being offered. Based out of south eastern Kentucky, at the Frontier School of Midwifery and Family Nursing, the new program called the Community Based Nurse-Midwifery Education Program [CNEP] has received hundreds of requests from prospective students all over the country. This program is designed to offer greater flexibility in graduate education for self-directed adult learners who prefer independent study or who are unable to relocate to existing nurse-midwifery settings. The program is self-paced and takes a student between 18 months and two years to complete. Students are oriented at Hyden, Kentucky and return there several times during the program for intensive seminars. Upon completion of this program, courses taken may be credited toward the Master of Science in Nursing offered by the Frances Payne Bolton School of Nursing at Case Western Reserve University.

The reasons that each program can only educate and prepare approximately 10 students a year are complex. Most importantly, the education is faculty-intensive, often times demanding a ratio of one faculty member for each student (for example, when faculty are supervising students caring for women in labor and while assisting with the birth).

The students who represent the pool from which nurse-midwifery students are selected are nurses. Most schools require that the student entering a CNM program complete her/his nursing degree at a baccalaureate level prior to starting nurse-midwifery education. This means that many students already possess student loans for $20,000 or more before admission to nurse-midwifery school. These students will than need an additional $18,000 to $43,000 for tuition, to complete their midwifery education. Prospective students often shy away from these financial obligations when learning that the average midwife's salary was only $36,000 in 1988. In addition, recent data from the American Nurses' Association indicates that staff nurses earn between $20,000 to $26,000 a year. The pool, then, does not consist of individuals who can easily pay the high costs associated with nurse-midwifery education. Compounding this problem, part-time education in nurse-midwifery is almost impossible because of the rigorous demands placed on students to be on-call for births—whenever they occur.

At Georgetown University it costs a full time student nurse-midwife approximately $22,000 for tuition and books. This does not include room and board for sixteen months. Students in the fulltime program cannot work and so they are without income during this period. In addition when they graduate, beginning salaries for nurse-midwives in this area are currently in the range of $38,000. Yet these students are the providers that are interested in going into inner cities and rural districts to improve the welfare of mothers and babies in this country. According to the latest report from Secretary Louis Sullivan, the nation still has along way to go to catch up to the rest of the world with regard to reducing infant mortality. Well educated and well prepared nurse-midwives can help our nation meet these needs.

For these reasons, federal support of nurse-midwifery educational programs is vital to the continuation of these programs, even though the President's 1992 budget request eliminates all funds for the education of nurses, including nurse-midwives. Thus we appreciate this opportunity to address this issue to you today and to urge Congress to reauthorize funds for these programs.

Today, there is yet another new trend that is further complicating the process of educating nurses to become certified nurse-midwives—less women are selecting nursing as a career. Nursing shortage rates average almost 9 percent despite hospital efforts to increase nursing service. The nurse-midwifery programs are beginning to feel the shortage of nurses qualified to meet the stringent standards of the nurse-midwifery educational programs. Federal funds to the programs indirectly decrease the tuition costs while the federally sponsored traineeships to students help to offset costs in yet another way. These funds provide incentives to students to enter these nursing programs, especially helping to finance minority students in need of education stipends.

Directors of all thirty educational programs are also seeking additional sources of funding—from state governments, from private foundations and from faculty generating service dollars. This later practice is dependent on the state laws under which a CNM is licensed, as well as the CNM's ability to gain hospital privileges—barriers to practice which still restrict nurse-midwifery in some areas of the country. In fact, the availability of this option for nurse-midwifery faculty is much more limited than for faculty at medical schools. Faculty are further limited since they provide care for underserved patients and this type of health care service cannot subsidize the educational programs.

Return on Investment

The federal funds that have been spent over the past ten years on nurse-midwifery education have been repaid many times over by CNM's services to the poor and underserved in the United States.

Today, nurse-midwifery practices exist in all 50 states, and in many developing countries around the world. Certified nurse-midwives can be found in hospital settings, in clinics, and in privately owned birthing centers. Fortunately the tradition of providing care to the poor continues. This is especially important in light of information which indicates that obstetricians are caring for smaller numbers of Medicaid clients.

A Safe Cost Effective Alternative

Over the years nurse-midwives have maintained a superb record of safety and client satisfaction. Nurse-midwifery is also a highly cost-effective approach to health care delivery. Hospital stays tend to be shorter and care regimens less technologically complex when not medically necessary with nurse-midwife assisted deliveries.

A Significant Contribution To Healthier Births

One of the maternal and infant health objectives set by Healthy People 2000 is to: "Increase to at least 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy". This objective is imperative since early, high-quality prenatal care is critical to improving pregnancy outcomes and reducing neonatal mortality.

A number of studies have shown that care by nurse-midwives increases utilization of prenatal care facilities, and that such care lowers the risk of low birthweight, prematurity and neonatal death. Recent reports by the National Academy of Science's Institute of Medicine, the Southern Governors' Association Task Force on Infant Mortality and the Children's Defense Fund highlight nurse-midwives' outstanding contribution to preventing low birthweight.

Another objective stated by Healthy People 2000, "Increase to at least 60 percent the proportion of primary care providers who provide age-appropriate preconception care and counseling" also can be achieved by using nurse-midwives as providers. Certified nurse-midwives endure that their patients are healthy prior to pregnancy, there by reducing the risk of problem pregnancy and poor outcome. We care for all women regardless of income, social status, or ethnic background.

Present Needs

A. Funding Needs. At this time we are requesting reauthorization level of 12 percent for each year (current level $21 million) to meet the educational needs of nurse-midwives/nurse practitioner programs. Presently, only nine nurse-midwifery programs are being funded. The additional funding requested is only enough to fund 4 to 6 additional new nurse-midwifery/nurse practitioner programs each year. These funds will help afford student scholarships as well as provide educational supplies, equipment and help pay for faculty salaries.

The program at Georgetown University graduates 15 students annually.

B. New Program initiatives. A study completed by the Bureau of Health Professions shows that there are approximately 5,000 foreign trained nurse-midwives living in this country.

Currently there are only two precertification programs preparing foreign trained nurse-midwives to qualify them to "sit" for the National Certification Exam. These programs consist of a 6 to 8 month course in theory and clinical practice. Tuition costs at the State University of New York are currently $1,800. At the Frontier School of Midwifery, complete program costs, including room and board, are $8,000.

Creating new precertification programs is an excellent way to expedite the supply of nurse-midwives. However, federal funding is needed to accomplish this goal.

Summary

The American College of Nurse-midwives urges Congress to appropriate funding levels adequate for the educating of sufficient numbers of nurse-midwives.

Certified nurse-midwives have a rich tradition of providing access to care for the poor and other underserved populations. This service more than compensates for the federal funding which has supported the educational programs in the past.

Continued growth of nurse-midwifery in the United States will help address two serious national health problems—the persistently high rate of low birthweight and premature births, and the rising cost of health care.

Mr. BRUCE. Now we will hear from Jan Towers, Director of Government Affairs for the American Academy of Nurse Practitioners.

STATEMENT OF JAN TOWERS

Ms. TOWERS. The American Academy of Nurse Practitioners presents this testimony regarding the need for continued and increased authorization of Federal funding for nurse practitioner educational programs for fiscal years 1992, 1993 and 1994.

It is common knowledge that medical care costs in this country continue to rise and that the shortage of primary care providers continues to be acute. It is also clear that the need for primary care providers willing to care for mothers, children and the elderly regardless of socioeconomic status is and will continue to increase into the next century. Based on that information alone, the need to continue to authorize additional funds for nurse practitioner education is apparent. The problems described above are not going to be resolved until there are sufficient numbers of primary care providers who can provide quality, cost-effective care to people of all walks of life. Nurse practitioners are those providers.

Little needs to be said about the quality of care provided by nurse practitioners. That quality has been well documented in numerous studies over the years. Likewise, the issue of cost effectiveness has been documented time and again in the areas of preparation, charges for services and reduction in hospital days. It has been estimated that if nurse practitioners were properly utilized, a yearly cost savings of $1 billion per year could be recognized. It would seem, therefore, to be in the Federal Government's best interest to maximize its investment in the preparation of these primary care providers.

There are four positions currently available to every nurse practitioner upon graduation. That figure would translate to approximately 6,400 unfilled positions at the current time. Given the previously stated need projections, this figure can do nothing but increase.

Nurse practitioner programs are funded through student tuition, institutional support, some State governments and the funding received from the Federal Government. There is no other known means of support for such programs at this time. Currently, only 71 nurse practitioner programs are able to be funded by the Federal Government at a mean rate of $130,000 per program under the amounts appropriated by Congress in the current fiscal year. Costs for running programs this year have increased 12 percent over those reported for the previous year.

Presently, there are 15 nurse practitioner and nurse midwife programs reported to be approved but not funded under the 1991 appropriation. This number is projected to rise as the number of applicants increases during the current year.

Given these figures, it would take approximately $8 million at today's costs to prepare nurse practitioners to fill the currently needed 6,400 positions identified above. It will take between $1.9 million and $3.1 million depending on the ratio of nurse practitioner to nurse midwife program applicants to fund the current 15 approved but unfunded programs using 1990 funding figures.

If indeed program costs continue to increase by 12 percent, and we have no indication that they will not, these amounts will range from $2.1 million to $3.5 million. This projection already exceeds the current authorization of $21 million for fiscal year 1991 and does not take into account the increased need for nurse practitioners as primary care providers in the next 3 years.

Based on these figures and the recognized need for more nurse practitioners in the near future, it is our recommendation that the authorized amounts for funding of nurse practitioner and nurse midwife programs be no less than 12 percent over the current level of authorization of $23.5 million for fiscal year 1992, $26.4 million for fiscal year 1993 and $29.5 million for fiscal year 1994. Given the magnitude of need, this is clearly a modest increase.

As we have stated before, nurse practitioners and nurse midwives are particularly well prepared to meet the growing health care needs of this country. The majority of their practices consist of those people projected to be most in need of access to primary health care services: the elderly, mothers and children and the poor.

In a national survey conducted by the American Academy of Nurse Practitioners, over 50 percent of patients seen by family, pediatric and women's health nurse practitioners had annual incomes of less than $15,000 per year. Gerontologic nurse practitioners reported that 81 percent of the patients they saw were also in that income bracket. Likewise, over 75 percent of adult and family nurse practitioners, 97 percent of gerontologic nurse practitioners and 70 percent of women's health nurse practitioners provide primary care services to people over the age of 65.

The educational preparation of these practitioners emphasizes the provision of care to patients who have limited resources, financial and otherwise. It seems logical, then, in light of the increased need to provide primary care to the medically indigent and to a growing number of elderly and children in this country, that such an authorization would be a wise investment and should indeed be even larger than the amount suggested.

Likewise, if any attempt is to be made to deal with primary care provider shortages and the spiraling medical care costs in this country, increased investment in cost effective primary care providers such as nurse practitioners and nurse midwives who are interested in prevention as well as cure, needs to become a priority.

We wish to thank the members of the Energy and Commerce Committee for its efforts in behalf of nurse practitioners and the people they serve. We know you recognize the value of our services and the needs of the people we serve. We understand the difficult task you have before you in light of the current need for fiscal constraint. We can be part of the solution to current problems regarding access and spiraling costs.

If there is anything we can do to provide further information or assistance regarding this issue, please call on us.

Mr. **Bruce**. Thank you, Ms. Towers.

Now we will hear from Lorraine Jordan, director of government affairs at the American Academy of Nurse Practitioners.

STATEMENT OF LORRAINE JORDAN

Ms. **Jordan**. I would like to say thank you for allowing me to address you and, second, thank you very much for sponsoring CRNA's schedule in OBRA 1990.

Mr. Chairman and members of the committee, my name is Lorraine Jordan. I am a certified registered nurse anesthetist [CRNA] and the director of education and research for the American Association of Nurse Anesthetists [AANA] appearing on behalf of our members, which consists of more than 24,000 CRNA's nationwide.

Our concern is definitely related to access to health care in this country.

We participate in all type of practice settings, hospital, clinical, outpatient, opthomology clinics. We participate in all types of surgical cases—open heart, cataract surgery, transplantation—so we have an opportunity to participate in any type of surgical case that is occurring within the patient setting that we see today.

The vast majority of anesthesia providers that served in Desert Storm were CRNA's. This added to a definite increased need of CRNA's across this country and a demand for nurse anesthetists.

This was seen heavily in the State of Kentucky. Due to the shortage that they experienced by deploying CRNA's from the State of Kentucky they have contacted me as of last week—the University of Kentucky—to ask me to help them set up and design a nursing anesthesia program.

I am here to request continuing authorization for nursing anesthesia programs at the following levels: $6 million in 1992, $8.7 million in 1993, and $11 million in 1994. I would like to ask that those levels be used for the following purposes: traineeships for nurse anesthetists, faculty development funding and funding to start and expand nursing anesthesia programs in the country.

As I stated before, our concern is access to health care in this country. In a congressionally mandated manpower study conducted in 1988 done by CHER, which is the Center for Health Economics Research, they indicated in 1990 we needed over 6,000 more CRNA's in this country. By the year 2000 we will need over 30,000 CRNA's to meet this demand they have projected. We will need to graduate 1,800 students per year. Currently, we are graduating 650.

I would like to also mention that within this study this also included anesthesiologists still graduating from residency, an increase in number of residents.

The quality of our program is not increase in applicants. Our problems revolve around increased need and expansion of programs. To start a nursing anesthesia program, it costs about $300,000. We estimate we need about 15 nurse anesthesia programs to meet the need. This time we were funded at $450,000. We hope—the application date for that particular grant is the end of this month, so we don't know how many applicants we have. I can tell you in my office alone I have had over 20 inquiries.

There has been $150,000 designated to start three nursing anesthesia programs. I personally know of eight applications that will be going into division of nursing for this funding.

We are also asking for funding for traineeships for students. Our students put in over 60 hours a week. Therefore, it is difficult to impossible for a student to continue to work. In our programs we require over 800 hours of anesthesia, over 450 cases, and the programs last a minimum of 24 months.

We are also asking for money to be spent for faculty development. In our programs we have 84 programs currently of which 8 of our program directors possess a doctoral degree.

I want to thank you for your past support. In 1990 you authorized $1.8 million and we were appropriated $1.43 million. We have been able to serve 33 faculty with the funding and 622 students with that funding, and we don't know how many nurse anesthesia programs we will start, but I am sure we will start three. Our support—from a Federal level, we appreciate anything you can do.

Our Association has designated one-quarter or 25 percent of our budget to education. That has increased dramatically in the last year. We also formed a National Commission on Nursing Anesthesia Education, developed goals and strategies and are implementing and funding those through our Association. We have asked State associations to take an active role in relationship to helping fund startup costs.

I want to thank you for your time, effort, energy and funding support in the past. I will be happy to address any questions you may have.

[Testimony resumes on p. 195.]

[The prepared statement of Ms. Jordan follows:]

TESTIMONY

of the

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Mr. Chairman and Members of the Committee, my name is Lorraine Jordan. I am a certified registered nurse anesthetist (CRNA) and the Director of Education and Research for the American Association of Nurse Anesthetists (AANA). On behalf of our membership which consists of more than 24,000 CRNAs nationwide, I appreciate the opportunity to provide this testimony in support of a three year reauthorization of the Nurse Education Act (NEA). Specifically, the AANA requests that nurse anesthesia educational programs be continued and authorized at $6 million in Fiscal Year 1992, $8.7 million in Fiscal Year 1993, and $11 million in Fiscal Year 1994 for the following purposes:

- Nurse anesthesia traineeships
- Educational development for faculty
- Expansion and creation of new nurse anesthesia programs

Mr. Chairman, we are all deeply concerned about the well documented and critical shortage of nurses in this country and its devastating effect on access to health care for millions of Americans. We commend this Subcommittee for its ongoing support of the nursing profession and for your current efforts to ensure that there are sufficient opportunities and incentives for individuals to pursue the profession, both on an undergraduate and graduate level.

We believe that the goal of resolving the nursing shortage is achievable, but it will require a cooperative approach between private and governmental (both federal and state) sectors. Nursing must offer sufficient rewards as a career to attract bright young people who are capable of meeting society's health care needs with a combination of "high touch" and "high tech" skills. We believe that the practice of nurse anesthesia offers today's youth an excellent opportunity for professional fulfillment.

BACKGROUND ON NURSE ANESTHESIA PRACTICE

Certified registered nurse anesthetists have administered anesthesia for over a century. Currently CRNAs provide quality anesthesia care to more than 65 percent of all patients undergoing surgical or other medical intervention which necessitate the services of an anesthetist, from the simplest to the most complex. CRNAs are the sole anesthesia providers in 85 percent of rural hospitals, affording these medical facilities obstetrical, surgical, and trauma stabilization capabilities.

Data in a 1988 Center for Health Economics Research (CHER) study demonstrated that there is no difference in anesthesia outcomes based on whether the provider is a CRNA or an anesthesiologist. CRNAs work in a variety of practice settings -- as hospital employees, as employees of physicians or physician groups, and as private contractors. CRNAs can be found in the U.S. Military, the Public Health Service, and Veterans Administration medical facilities. Most recently, the vast majority of anesthesia providers mobilized for Desert Shield/Desert Storm were certified registered nurse anesthetists.

CRNA SHORTAGE

The 100th Congress mandated a study to determine the extent of the nurse anesthetist shortage. In February of 1990, the Department of Health and Human Services (HHS) released a study conducted by Health Economics Research, Inc. (HER) documenting a critical shortage of nurse anesthetists. It is important to note that the study factored in projected increases in the number of graduates from anesthesia residency programs in determining the future need for additional CRNAs. The study reported a shortage of 6,000 CRNAs for 1990, or a 13.6 percent shortfall. It further reported the need for 30,000 CRNAs by the year 2000, and over 35,000 CRNAs by the year 2010. To meet this need, the educational system for nurse anesthetists will have to graduate 1,800 students yearly between now and the year 2000, and 1,500 graduates per year thereafter. The loss of nurse anesthesia educational programs since 1984, however, has resulted in a decrease in the number of graduates from approximately 1,100 to 650 nurse anesthesia graduates in 1990. The decrease in graduates is not, however, related to a decreased pool of applicants. Data indicates that there are three qualified applicants for every one available student vacancy in a nurse anesthesia program.

The HHS report cites three primary reasons for the CRNA shortage: a decline in the number of educational programs, a lack of clinical training sites for students, and an increased demand for anesthesia services.

DECLINE IN NUMBER OF EDUCATIONAL PROGRAMS

The HHS study documents recent declines in the number of educational programs that prepare registered nurses to become anesthetists and the concomitant decrease in annual graduations of CRNAs. The leveling off in the number of CRNAs has been attributed to two waves of educational program closures. The first wave of closures occurred during the latter part of the 1970s, when many of the smaller, hospital-based certificate programs closed as a result of the adoption of higher accreditation standards. Concurrently, the profession adopted a goal supporting the premise that the education of nurse anesthetists should be conducted at the post-baccalaureate level. Additionally, closure of some nurse anesthesia programs in large community hospitals occurred because of concerns about the cost of nurse anesthesia education in a Medicare Prospective Payment System environment. A second wave of closures has been largely attributed to the denial of clinical access to nurse anesthesia educational programs because of the increase of anesthesiology resident positions.

LACK OF CLINICAL TRAINING RESOURCES

The first year of most of the nurse anesthetist educational programs is typically devoted to classroom instruction; the second year is given to clinical practice. In fact, in order to graduate, nurse anesthesia students are required to provide a minimum of 800 hours of anesthesia through participation in at least 450 cases. An average student participates in 600 cases and administers over 1,000 hours of anesthesia.

However, clinical training resources in some academic health centers have been shifted from nurse anesthesia educational programs to anesthesiology residency programs. The result has been an inability to access sufficient clinical training opportunities and the subsequent closure of a significant number of nurse anesthesia educational programs. Ironically, the very hospital settings closing nurse anesthesia programs are at the same time increasing their utilization of nurse anesthetists.

Additionally, while there are only about 250-300 more anesthesiologists per year being prepared than in the early 1970's, the expansion of the anesthesiology medical residencies from three to four years has increased the utilization of training resources by 25 percent. In 1972, approximately 750 anesthesiologists were graduated from residency programs. The Center for Health Economics Research projects that the current number of anesthesiologists graduating from residency training will decline from the current 950-1000, to 800 by the early 1990's. This number, when considered with the number of anesthesiologists who subspecialize in areas of practice outside of the operating room setting, will not permit a significant increase to meet increasing anesthesia service demands.

INCREASED NEED FOR ANESTHESIA SERVICES

In addition to the shortage of nurse anesthesia programs and lack of clinical sites for nurse anesthesia students, the third principle cause of the CRNA shortage is an increase in demand for anesthesia services. The proliferation of ambulatory surgicenters and physician office surgical facilities had greatly increased the need for qualified anesthesia providers. While implementation of the Medicare Prospective Payment System was early associated with a decreased bed occupancy within hospitals, the surgical workload necessitating anesthesia services did not decline. In fact, we are seeing a constant increase in medical interventions needing anesthesia coverage.

A measure of the shortage of CRNAs can be viewed from a variety of sources:

- Job placement advertising in the AANA News Bulletin has jumped from an average of 25, to more than 300 monthly.
- The authorized levels in the three military services for both active duty and reserve CRNA forces total about 1,630; the current actual levels for active duty and reserve CRNAs total about 1,040.

CRNAs ARE VALUABLE, COST EFFECTIVE HEALTH PROVIDERS

Anecdotal evidence indicates that the opportunity to enter our specialty area actually keeps some critical care nurses from leaving the nursing profession. For although our specialty can be as stressful as critical care nursing, we only deal with one patient at a time. We have the opportunity to devote our complete attention to that patient while providing individualized anesthesia care. In many practice settings, CRNAs have a great deal of autonomy and receive salaries commensurate with their demanding practice conditions.

The 1988 CHER study concluded that the increased use of CRNAs to deliver anesthesia could save the nation $1 billion annually by the year 2010. This is due in part to the fact that the average 1990 pretax income for a CRNA was $60,000; the average net income for an anesthesiologist in 1990 was $180,000. CRNAs afford the greatest opportunity for containing the cost of anesthesia care in this country in the future. In fact, the profession as a whole is committed to doing its share to hold down the cost of health care in this country. This is, in part, why Congress passed legislation making the CRNA the first nursing specialty eligible for direct reimbursement under Medicare. At that time, the AANA and its members agreed to a provision that mandates Medicare assignment by all CRNAs. In contrast, anesthesiologists can balance bill Medicare beneficiaries; only 30 percent of the approximately 20,000 anesthesiologists in the United States are Medicare participating physicians.

NEED FOR NEW PROGRAMS

It costs approximately $300,000 to start and run a new nurse anesthesia program, and we estimate that 15 new programs are needed over the next three years to educate the necessary numbers of CRNAs. We are grateful for the fact that funds are, for the first time this year, available to assist in the costs associated with starting new programs. However, the $450,000 available will only provide assistance to three new programs, at an average of $150,000 per grant. Although the application deadline for the new program grants extends until May 31, 1991, the AANA office has already received 20 requests for information regarding the submission of a grant application.

Our funding requests for nurse anesthesia programs would allocate the monies based on the areas of greatest need: one half of the amount authorized for each year would be used to expand and begin nurse anesthesia programs. The balance of the authorized amounts would be utilized for nurse anesthetist traineeships and faculty development.

NEED FOR NURSE ANESTHETIST TRAINEESHIPS

Nurse anesthesia educational programs are from 24 - 36 months in length, many of which are graduate programs in academic settings. Our applicants must either have a bachelor of science degree in nursing or other appropriate degree for admission. They must also have at least one year of professional nursing experience in an intensive care setting; many have from two-four years of experience.

The average cost per year for a student to attend a nurse anesthesia program ranges from $13,000 to $19,000 at a state university, and $18,000 to $34,000 at a private institution. These figures do not include forgone income that the student would have had as an experienced critical care nurse.

In Fiscal Year 1990, although $1.8 million was authorized for nurse anesthesia programs under the NEA, only $1.43 million was appropriated. It allowed only 33 individuals to receive faculty development funding. In addition, this allowed only 622 nurse anesthesia students to receive traineeship funds; the amount each of those students received was less that $2,000. Because of limited dollars, only students in their second year of the nurse anesthesia educational program are eligible for these funds at this time. This, too, is a barrier for entry into the profession because of the expenses and heavy financial burden placed on nurse anesthesia students. AANA believes that more nurses would enter nurse anesthesia programs if sufficient funds were available to allow for assistance during the entire span of the educational program.

NEED FOR FACULTY DEVELOPMENT

Today, there are 84 nurse anesthesia educational programs in the country. Ideally, as contended by most professional and academic educational experts, all program directors should hold a doctorate degree. To date, only 8 of our 84 directors hold such a degree.

On a related note, the faculty of any higher education program should hold, at a minimum, a Master's degree when teaching students enrolled in graduate programs leading to the Master's degree. Today, there are over 900 CRNAs without Master's degrees who are serving as faculty in such programs. Many of these CRNAs need to pursue a Master's degree, but it virtually impossible for them to do so under current time and financial constraints. We are trying to relieve this problem by preparing more of our nurse anesthetists at the graduate level. Approximately 70 percent of the graduate nurse anesthetists taking the certification examination have a Master's degree. However, it will be some time before these graduates will be sufficiently experienced to assume major responsibility in our educational programs.

Completing a Master's degree in anesthesia or a related basic science field requires approximately two years of full time study. Completing a doctoral degree will take from three to five years of study, depending upon how much time can be taken for full time study. Graduate educational cost, including tuition, fees, and textbooks, can range from approximately $6,000-$10,000 per year in state universities, to close to $30,000 in private institutions. We are hopeful that sufficient funding will be available in the next three years to allow at least five percent of our current faculty to go back to school to obtain the necessary graduate education and credentials for our educational programs.

SUMMARY

We realize that our reauthorization level requests entail significant increases over the previous authorization levels for CRNAs. However, we believe that in order for CRNAs to help you assure access to health care for all Americans, we need to have access to continued financial support from both the private and governmental sectors. Rest assured that we are not looking only to the federal government for help with the current CRNA shortage. We are more than willing to do our part on the national level, as evidenced by the fact that our association dedicates over 25 percent of our resources to education issues. Several of our state associations have also demonstrated their commitment to education by funding the costs of the initial start-up for new programs, as well as scholarships for nurse anesthesia study. In addition, the AANA is working closely with state and local governments, as well as the private sector, to raise funds to educate more nurse anesthetists.

Mr. Chairman, thank you again for your past support for nurse anesthesia programs and for your consideration of our request. I will be happy to respond to any questions you may have at this time.

Mr. **Bruce**. I thank the panel for your testimony.

Ms. Kozeliski, I was just curious. As a nurse in New Mexico, what are the practical problems you face in a nursing shortage in your hospital? What do you see on your floor? Are you practicing nursing now?

Ms. **Kozeliski**. I am Director of Education right now. I am on the Advisory Committee's floor. We have a program in the town and some of the funding NEA did is a site program in Gallup itself. We were talking about access delivery. It is also access to the system for education. A lot of it is monetarily impossible for some of the people in our area because of the lower socioeconomic status that the people have anyway.

Mr. **Bruce**. Scholarships would fill the gap more than increased salaries for nurses who are trained but not practicing?

Ms. **Kozeliski**. That could be part of it. I don't know if that would be the total. I don't think that would be the help immediately, no.

Mr. **Bruce**. Ms. Carty, you indicate that you have a faculty shortage to where you turn down 2,300 applicants. Ms. Jordan indicated faculty development. What is your position on faculty development? How can we attract faculty into your colleges and institutions?

Ms. **Carty**. Support for advanced nursing training is one way of doing that because through that program we can prepare people at the master's level who can serve as faculty in a variety of specialty areas and then hopefully those—some of those people who would go on for doctorates at a later date—but it is vital that we do have that support for advanced nurse training in order to prepare that very crucial need for faculty. We are experiencing shortages across all specialties in faculty, and I think the community may be aware that there is a drain of the American academy not only in nursing, but nursing is not exempt from that. So we have a great need in that area.

Mr. **Bruce**. In your testimony you spoke favorably about special projects. Is there one or two in particular that you thought has been unusually successful, and do you see any other special projects we ought to be funding?

Ms. **Carty**. There are a variety of special projects I think have been very successful in the country.

I can speak to one that we had at George Mason that ran for 5 years that really was focusing on ethical decisionmaking in the practice arena, and we were able to bring in nurses from a three State area and work with ethical decisionmaking around questions of allocation and scarce resources and how to deal with these types of problems as they come up.

It was a very successful special project grant that resulted in a monograph, resulted in a newsletter which has been mainstreamed. We continue. It is called "Ethics Forum." Resulted in a videotape series on ethical theoretical development as applying to case studies. That is an example I am most familiar with.

As a peer reviewer in Division of Nursing I can tell you I have reviewed many innovative kinds of programs through special projects.

I can remember one in Montana that provided a bus that was a healthmobile type of arrangement where nurses from the University of Montana were able to outreach into communities—underserved communities—to—there was an involvement of faculty and students in the actual delivery of services to an underserved population, and I think that was about a 5-year funded project.

There are a number of nurse clinics that are funded through special projects. There are a number of programs that help career ladder nurses from LPN to ADN or LPN to BSN targeting minority populations. These have all been very successful programs and need to continue.

Certainly there are other areas. When we look at our population that surrounds us, particularly in our Nation's capital and our surrounding States, we look at the numbers of international people that we have and the health care needs that they have that are somewhat different culturally based needs.

I think special project grants could help prepare practicing nurses to better deal with the cultural kinds of differences that exist in that population out there that need care.

Those are some things that I can think of.

Mr. **Bruce**. Ms. Bash, you mentioned a successful program that was beginning in Kentucky, a self-directed, self-taught program. Is that ongoing, or what is the status of the program in the State of Kentucky?

Ms. **Bash**. That program started about a year and a half ago. And if you give me a moment to pull out some statistics on that, their first class was admitted in August 1989, with 41 students. Now these students are students from all over the country. They come to Hayden, Ky., for an initial 2 weeks intensive seminar and orientation, and they then return to their home base or the hospital where they have acquired a certified nurse midwife as a preceptor. They work on individual modules and do study groups and come back every few months to Hayden for orientation, for examinations and for seminars.

The first group of students will be taking their certification board for American College Board Midwife Certification Program this spring. The students presently—it is costing the students approximately $15,000 a year. Of course, this includes travel back and forth to Hayden, Ky., their tuition, books, lodging and food when they stay at Hayden.

Mr. **Bruce**. I take it that is not a suburb of New York so that is not the easiest place to get to?

Ms. **Bash**. Exactly. But the Frontier Nursing Service was the first service of nursing midwives here in the United States, and it is probably very appropriate they be the first innovative program of nurse midwifery in this country.

Mr. **Bruce**. You are also suggesting we somehow utilize the talents of the foreign trained nurses. Do you see a problem in certification in the sense of going back to schools that no longer exist and checking out library and faculty that have dispersed or are no longer in existence?

Ms. **Bash**. I think when one becomes a certified nursing midwife one must first be a registered nurse in a State in this country. Most of them have basic nursing education at baccalaureate level.

They come into a program which reviews their ability to be midwives.

Mr. **Bruce**. Ms. Towers, you mentioned you are working in a migrant health center. Does it concern you at all by providing service through a nurse practitioner we may be reducing the quality of primary care to certain individuals in the country by not having a fully licensed physician there?

Ms. **Towers**. I don't think I provide lower care nor do I think any nurse practitioner does. I think the studies have demonstrated the quality of the care we provide is equal to that of physicians in the areas we are working. Quite frankly, in the clinic I am in, where we have three nurse practitioners and a nurse midwife, the quality of care has considerably improved since the nurse practitioners have began working with these patients.

Mr. **Bruce**. Very good. When I was a State legislator almost 18 years ago I authorized creation of nurse practitioners in the State of Illinois.

Ms. Jordan, on your faculty development, how do you believe we ought to proceed?

Ms. **Jordan**. Basically, we received—this is the second year we received faculty development funding. They had so many applications the first and second year this year it was difficult for the division to decide who would receive the funding. We have CRNA's who want to get their graduate degrees. This has offered them a wonderful opportunity to do that as well as getting those credentialed individuals we need. It has not been difficult to get people to participate or even applications. The Division of Nursing has said this year they had a difficult task in determining who would receive that funding and who would not.

Mr. **Bruce**. Thank you.

Mr. Richardson, do you have questions of this panel?

Mr. **Richardson**. I would like to ask Dr. Towers—along the same lines I understand Congressman Towns asked—and that is the nursing assistants, the lack of options that they have because of our emphasis on graduate education. I am talking about the low paying paraprofessional positions. Because of low salaries and family obligations, a lot of these people may not have the opportunity to pursue an education leading to an RN degree. And I am wondering—while I understand the need to have trained faculty, are there ways to provide better opportunities to LPN's, LVN's, nursing assistants to move up the nursing career leader? Aren't we kind of degrading and not emphasizing that side of the profession?

Ms. **Towers**. I would not say we are degrading it. I think one of the things that is occurring now—and maybe the nursing shortage has helped a little bit with that—is that there is much more attention being placed on attempting to dovetail educational programs so that indeed people in areas that either limit their preparation or limit their accessibility to university centers where they can have advanced preparation are being able to work more speedily and in a more cost effective way toward achieving the kind of education that is needed for them to be advanced practitioners.

The other kind of thing that is beginning to develop is the kind of thing that Deborah just mentioned with community based programs which allow people in areas that are not close to university settings to access educational activity from a distance through telecommunication, through outreach course offerings, that sort of thing.

And I think we are seeing more and more of this occurring and a very large awareness on the part of the nursing community that this kind of thing needs to happen.

Mr. **Richardson**. Ms. Carty, I just noticed, I was involved I think also with Mr. Bruce several years ago with set asides for telecommunication education for nurses. As I understand it in your testimony that the Division of Nursing is not utilizing the funding set aside for this telecommunications education in the bill, what are they doing with this money? Are there ways we can improve on this program? What seems to be the problem?

Ms. **Carty**. I don't think they are not utilizing it. I think our point was it should not be confined to simply satellite telecommunication, that that is certainly an acceptable means and there are some very successful programs—in fact, there is one in New Mexico out of the university in New Mexico. What we are indicating from AACN is that that not be the only type of outreach that would be funded. So we would urge that other means of outreach be also eligible for those funds.

Mr. **Richardson**. Like what? Because the reason we had telecommunications was to really go deep into the rural areas, Indian reservations—when you start diluting that and saying other outreach, what do you mean? Doesn't that dilute the intent of what we are trying to do?

Ms. **Carty**. I would not think so. I think there are some areas where the telecommunication capability may not be there and the cost of developing that whole network is in some instances prohibitive.

And another means of outreach could occur where faculty can travel to outreach sites where computer linkages can be used through some existing networks that are already in place through the—I referred to the healthmobile before, but there are some mobilized outreach programs where they are using buses to move faculty and library and computer kind of resources into these rural areas so nurses can access that kind of education.

And our point is that we would not want to eliminate those types of outreaches from funding.

Mr. **Richardson**. Let me ask my constituent, Ms. Kozeliski—that is, I understand you recently worked on a very innovative health delivery program grant proposal to provide primary health care to Native Americans using nurse providers. Can you tell us a little bit about that program and where you expect to receive funding for it?

Ms. **Kozeliski**. This is the one we just applied to. Is that the one you are alluding to?

Mr. **Richardson**. Yes.

Ms. **Kozeliski**. We developed a consortium in our community. This is a federally funded grant. I believe it was $300,000. I don't have the exact agency in front of me right now. The Indian Health Service, the Gallup through Grants Clinic, and the institution I work for got together and we had a task force that decided we would like to apply for funding for just what Ms. Carty was saying, mobile type of clinic, and addressing the primary needs of the people of the area.

We have a large Native American/Hispanic population where their problems deal with drug and alcohol abuse, kidney disorders, diseases and diabetes. We were looking at having some kind of a mobile clinic that would be able to go out into the areas—you have to realize in the area where we are at it is not unusual for someone to travel 40 or 60 miles just for a doctor's appointment. If it is not that important, even if it happens to be meningitis for a child, maybe the child dies.

There are areas where they go feed their cattle, water wells where people congregate also. So it wouldn't be a traditional health care setting. We would use this vehicle, perhaps with the University of New Mexico with some of their nurse practitioner and midwifery program for onsite practicum experience for nurses and for residents, physician type residents, helpful recruitment type tool for our area. That is what we are looking at.

Mr. **Richardson.** Thank you.

My last question is directed at the legislation that Congressman Dorgan and I had allowing nurse practitioners to be directly reimbursed for Medicare. Could any of you tell me when this legislation has been implemented, how successfully implemented is it? Are nurse practitioners now being reimbursed—lastly, I understand there were some specific problems in New Mexico that dealt with direct reimbursement, that there were serious problems that it was not happening. Dr. Towers.

Ms. **Towers.** The answer is first, yes, it is being implemented. It is coming along. The other piece is that we still need to obtain Medicare reimbursement for the remainder of nurse practitioners. The bill that you are speaking of, of course, focused upon people in rural areas. This does not solve the problem in urban areas where there is also a great need. While part of the problem has been resolved, for nurse practitioners in New Mexico it has not entirely been resolved at this point.

Mr. **Richardson.** It has happened in rural areas and not urban areas?

Ms. **Towers.** That is correct.

Mr. **Richardson.** Why is that?

Ms. **Towers.** Because that is what the bill called for.

Mr. **Richardson.** So we should do it for urban areas?

Ms. **Towers.** You got it.

Mr. **Richardson.** Sounds like another one of Mr. Bruce's good bills for nurses.

Mr. **Bruce.** Ms. Bash.

Ms. **Bash.** I know nurse midwives are reimbursed for maternity care only. However, nurse midwives do a lot of preventive care, education and teaching. Presently we are not reimbursed for services other than just maternity care.

Mr. **Richardson.** Mr. Chairman, thank you very much.

Mr. **Bruce.** Ms. Towers, I have one question. I met with the administrative people of the fourth largest private practice clinic in the United States which is located in my district just the day before yesterday, and I asked them how many nurse practitioners they had, and they said 60. They seemed to be very proud of that.

Is that about consistent with medical practice of maybe 400 doctors, to have 60 nurse practitioners on the staff?

Ms. Towers. It could be. Nurse practitioners function in a variety of kinds of settings. You may have one on one. You may have a group of nurse practitioners who work in collaboration with one physician. You may have an HMO where you would use multiple nurse practitioners with multiple physicians. So that is a practical number.

Mr. Bruce. I want to know if we were doing good or bad.

Ms. Towers. I think you are doing good, but you ought to have 400.

Mr. Bruce. I thank the panel. Thank you.

We are ready for panel five. Our final panel will address the individual issues of concerned schools of allied health, public health and social work.

We will start out with Dr. Leo Selker, interim dean and professor of the college of associated health professions of the University of Illinois at Chicago. He will be followed by Dr. John Snyder, dean of the school of allied health sciences at Indiana University; Allan Rosenfield, dean of the school of public health at Columbia University; and Patricia Ewalt, dean of the school of social welfare at the University of Hawaii at Manoa, who is accompanied by Frank Raymond III, president of the National Association of Deans and Director of Schools of Social Work.

Dr. Selker—let's see—take you in the order I announced them. Dr. Selker, I understand you are from the University of Illinois from Chicago, one of the finest universities on this planet.

Happy to be joined by Mr. Towns.

Mr. Selker.

STATEMENTS LEOPOLD G. SELKER, ON BEHALF OF AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS; JOHN R. SNYDER, ON BEHALF OF AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS; ALLAN ROSENFIELD, ON BEHALF OF ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH; AND PATRICIA L. EWALT, ON BEHALF OF NATIONAL ASSOCIATION OF SOCIAL WORKERS, NATIONAL ASSOCIATION OF DEANS AND DIRECTORS OF SCHOOLS OF SOCIAL WORK, ACCOMPANIED BY FRANK RAYMOND III, PRESIDENT [NAD&DSSW]

Mr. Selker. Mr. Bruce, Mr. Towns, thank you for the opportunity to appear before you today. I would like to request that my entire written statement be entered into the record. Due to the time constraints I would like to summarize the major points in that written——

Mr. Bruce. Without objection.

Mr. Selker. Thank you, sir.

The major point I would like to really hit hard on today is the very serious and worsening shortage of allied health personnel and some rather important steps that might be taken to address that shortage.

Those severe shortages exist in a wide range, but particularly in physical and occupational therapists, clinical laboratory professionals, imaging technologists including radiation therapists, medical record technicians, speech-language pathologists and audiologists, the underrepresentation of minority persons in the allied health professions and an undersupply of practitioners in both rural and densely populated, poverty-ridden urban areas.

Looking toward the future, the circumstance seems to me more grave. Rapid growth in the population of older persons and their intense needs for various kinds of chronic and long-term care support will only intensify the picture I am painting for you today.

What is probably saddest is lack of Federal support. During the period 1981 to 1989 there were essentially no Federal programs targeting the allied health professions. During last reauthorization of title VII Congress authorized $6 million for each of 3 years but only $737,000 was appropriated for fiscal year 1990 and $1.6 million for the current fiscal year.

I guess these numbers are pretty depressing, but they are more sobering if you consider the allied health professions represent some 60 to 70 percent of our entire health care workforce.

You were exercising a major leadership role, Mr. Bruce, in your introduction of H.R. 1466 on March 19th. We applaud and support that legislation, but we also acknowledge the more comprehensive solutions certainly likely to require additional resources.

You had proposed $10 million or so for entry level traineeships, $7 million for advanced level traineeships and $7 million for grants and contracts. We would like to see $12 million for entry level traineeships, $12 million for advanced level and $12 million for grants and contracts. But even that really pales in comparison to the needs that we foresee.

Allied health research is a major necessity because faculty are being expected to compete in academic health science center environments. Their bread and butter and status within that academic community are very much contingent on their performance in the research area. We cannot hope to recruit without additional research support.

Moreover, since the allied health professions represent such a broad span of disciplines we also have not the best data upon which to base health policy decisions, and an allied health data system would also go a long way.

You proposed a commission on allied health. We hope some funds can be appropriated to support putting that commission in place.

Last, a more visible presence—by creating a Division of Allied Health within the Bureau of Health Protections would also serve as a lightning rod for coordinating the various programs needed.

Numerous studies, the National Institute on Aging 2020 study—all of these highlight the shortages of allied health professionals. What is not widely known, those shortages are probably grossly underestimated. If you consider the effects of cost containment, geriatric imperative health promotion disease prevention, medical technology which is going to move more care into the home, the explosive growth of the home care industry, the mainstreaming of persons with disabilities, the fact that persons of all ages are living longer with disabilities, the press for quality and outcomes research, the chronic care needs I touched on earlier, all of these are very likely to swamp the system in terms of need.

So if anyone feels that somehow the shortages are going to evaporate from this posture, we only see that things are going to worsen and worsen fast.

The cost containment pressures we feel are really going to spurn further experimentation including further substitution of high quality yet lower cost of allied health services for extensive forms of institutional care. Paradoxically, these costs are only driven higher as various 'health care institutions compete with one another through signing bonuses and incentive bonuses for these allied health professionals.

Home care, which is roughly a $22 billion industry this last year, is projected to more than triple by the year 2030. Allied health professionals are major players in the home care sector and along with nurses hold largest market share.

Chronic care needs, needs for activity in the area of health promotion and disease prevention, all of these lend nicely to the allied health professions by virtue of the skills of those allied health professions and because these professions are located in community based settings where access is really critical.

A major bottleneck in terms of addressing these shortages relates to the production of academic faculty. It is critical that we develop support mechanisms for those faculty, develop further training programs that are going to turn out these graduates.

We feel these short-term financial incentives that you have observed in the marketplace are not going to address the root problem, which is the further development in terms of both numbers and quality of allied health faculty. Therefore, we conclude the conventional market forces alone are going to fall far short of getting the job done, because they really don't speak to—those higher salaries in the marketplace don't speak to developing doctoral programs to produce more faculty or provide training to more current faculty.

We all have a great stake in reducing these shortages of allied health personnel. We authorize significant funding increases for title VII programs as a first major step in demonstrating a major serious commitment.

We thank you for the action you have taken and ask you continue to do so to ensure our Nation will be able to continue the health care needs of its citizens.

Thank you for the opportunity to share these views with you today.

[The prepared statement of Mr. Selker follows:]

Prepared Statement of Leopold G. Selker, on Behalf of the American Society of Allied Health Professions

The American Society of Allied Health Professions, a national nonprofit scientific and professional organization whose mission is to improve health care by enhancing the effectiveness of education for allied health professionals, urgently requests Congressional assistance to remedy a serious personnel shortage as manifested by:

(1) Severe shortages of physicians and occupational therapists, clinical laboratory professionals, imaging technologists including radiation therapists, medical record technicians, speech-language pathologists, and audiologists;

(2) The underrepresentation of minority persons in the allied health professions;

(3) An undersupply of practitioners in both rural and densely populated, poverty-ridden urban areas;

(4) A rapid growth in the number of older persons needing the services of allied health personnel; and

(5) A lack of Federal support for allied health education. During the period 1981 to 1989, there were no Federal programs offering such support. During the last reauthorization of Title VII, Congress authorized $6 million for each of three years, but only $737,000 was appropriated for fiscal year 1990 and $1,659,000 for the current fiscal year, amounts not even barely sufficient given the enormous problem that must be addressed.

Congressman Terry Bruce introduced H.R. 1466 on March 19 to amend Title VII to increase support for allied health. For fiscal year 1992, this bill seeks $10 million for entry level traineeships, $7 million for advanced level traineeships, $7 million for grants and contracts, and an unspecified amount for a Commission on Allied Health.

Our organization supports this legislation while wishing to acknowledge that a more comprehensive solution will require the following resources: Entry level traineeships ($12 million); advanced level traineeships ($12 million); grants and contracts ($12 million); allied health research ($20 million); allied health data system ($5 million); commission on allied health ($1.5 million); and division of allied health within the Bureau of Health Professions (5 FTE's).

Reports produced by a wide array of groups ranging from the Institute of Medicine to the American Hospital Association all point to a shortage of allied health personnel which is worsening. Because of the following health system trends, these shortages may be grossly underestimated:

(1) Intensifying cost-containment efforts will stimulate further experimentation, including the substitution of high-quality, low-cost allied health services for more expensive institutional care. Paradoxically, health costs are driven ever higher as institutions compete through signing bonuses and other incentives for a scarce supply of personnel;

(2) The number of older persons demanding some formal in-home services is projected to nearly triple by the year 2030. Allied health professionals hold a large market share in home care and are well-positioned to respond to these needs and preferences;

(3) Increased attention to those requiring chronic care will foster a greater demand for the services of allied health professionals; and

(4) Recent estimates reflect that roughly 60 percent of deaths are premature and about 60 percent of all illness and disability is preventable. Allied health professionals' participation in prevention and wellness activities will only increase by virtue of their skills and their being located in accessible sites such as schools, aging centers, and the workplace.

When lightning struck at St. Albans School here in Washington thirteen days ago, the 11 persons—including one fatality—who were rushed to local hospitals might just as easily have been either the children, spouses, or even members of this august body. None of us is immune from common occurrences such as accidents, strokes, and heart attacks which require the intervention of allied health professionals to prevent death and long-term disability. An insufficient supply of these practitioners is a problem that will not be solved by a quick fix. Producing academic faculty, developing training programs, and turning out graduates are not commodities that can be manufactured on short notice.

Physical therapy programs in our universities are swamped with qualified applicants, but we lack the faculty to accommodate them, despite the fact that all parts of the United States need more of these practitioners. Severe shortages of clinical laboratory professionals also exist, but the basic problem is remarkably different. Academic programs have been terminated because of a decline in the number of persons seeking admission to the laboratory sciences.

The grants and contracts program currently being funded through the Bureau of Health Professions represents one instrument that can be applied as part of a comprehensive solution. The small number of projects receiving funds aim to increase the ability of allied health professionals to meet the care needs of the aged, attract more minority persons to the allied health professions, and enhance the availability of clinical laboratory services in rural areas. Unfortunately, many other worthy projects have not been launched because of inadequate resources.

Conventional market forces alone cannot solve the personnel shortage problem, despite significant efforts undertaken by the private sector in Florida and other States. Competitive bidding for personnel by hospitals and other institutions will not stimulate financially strapped colleges and universities to produce more graduates. Offering higher salaries to those practitioners in greatest demand will not affect the funding needed to develop doctoral programs to produce more faculty or provide training to current faculty who in many cases either have only a masters degree or a doctorate in a areas outside of the basic sciences.

It is the belief of the American Society of Allied Health Professions that, as the largest consumer of health care, the Federal government has a great stake in reducing shortages of allied health personnel. This highly complex problem will not be remedied without such meaningful participation. Reauthorizing significant funding increases for Title VII programs is a first major step in demonstrating a serious commitment. We urge you to take such action to ensure that our nation will be able to meet the health care needs of its citizens.

Mr. BRUCE. Dr. Snyder, from the Indiana School of Allied Health Sciences.

STATEMENT OF JOHN R. SNYDER

Mr. SNYDER. My name is John Snyder. I am the director of the division of allied health sciences and associate dean at the Indiana University School of Medicine. Medical technology is my background. I spent the last 20 years in practice in the clinical laboratory as well as variety of levels in education preparing manpower for clinical laboratories.

I am pleased to present testimony on behalf of the American Society of Clinical Pathologists hereinafter referred to as ASCP. We are a nonprofit medical speciality society with more than 50,000 members.

It is the largest certified agency for medical laboratory personnel. Many of you are well aware of the extensive shortages of qualified medical laboratory personnel and its impact on laboratories, especially in rural areas.

ASCP estimates in 1990, the Nation's 12,000 hospital and independent laboratories had nearly 42,000 unfilled positions. In fact, as you heard earlier, the medical technology of vacancy rate of 11.6 percent exceeds the nursing vacancies experienced at the height of their shortage.

Medical standards may further increase the need for trained laboratory personnel, a need that according to the Bureau of Labor Statistics, is projected to increase by the year 2000.

Two factors have strongly influenced the shortages of medical laboratory personnel. First, the decline in education programs parallel the determination of Federal support for allied health education in 1981, second, there has been a significant erosion in hospital teaching programs, the major source of manpower, this due to the implementation of Medicare's prospective payment system in 1982.

ASCP supported reinstatement and funding of allied health education in title VII of the Public Health Service Act. In the first year, HRSA received over 100 applications for this program, approved almost 50 grants, yet funded only 7 grants.

Almost half of the approved grants were from medical technology programs, although none were funded due to the priority given to other professions and limited funds. The published special consideration regulations regarding 1991 funds for allied health continued to overlook certain specialities and short supply.

Truly the key to addressing the shortages of medical laboratory personnel is to bring more candidates into the field through educational programs therefore, ASCP is pursuing a two-pronged approach.

First, we would like to see the current allied health program broadened to address the needs of allied health specialities in short supply such as medical technology. These professionals are critical to providing the support needed in geriatric care and in breast and cervical cancer screening which are a high priority of the subcommittee.

We urge you, one, to reauthorize the allied health programs that are current or increase levels and, two, to incorporate language directing HHS to fund grants in shortage allied health professions as a high priority.

We are aware of your bill House Rule 1488, Mr. Bruce, which calls for funding for the specific shortage allied health areas. You are to be commended of that, and we are supportive of that bill.

The second prong of the ASCP approach is the dimensions of shortage problem require urgent focused attention by the Federal Government. ASCP urges this subcommittee to establish a special initiative in medical laboratory education by authorizing grants to schools, educating medical laboratory personnel as part of the reauthorization of title VII, The Health Professions Education Act.

The projects should include, first, scholarships and/or stipends for medical technology, cytotechnology and histotechnology for their clinical training when students agree to work in rural areas.

Second, grants to schools willing to form a consortia arrangements that links academic resources with rural clinical settings.

Third, grants to schools that recruit nontraditional students such as minorities and science professionals into the fields of medical technology and cytotechnology.

Fourth, grants to schools that provide refresher courses for individuals who have not been working in the field for several years.

Finally, grants to schools for recruiting and training medical laboratory technicians to become medical technologists.

We are pleased this initiative has been well received within the medical laboratory community and that nine organizations have offered their support. We are encouraged thus far and hope the subcommittee will continue to incorporate these proposals into legislation.

We would like to comment on H.R. 2405, the Rural Clinical Laboratory Personnel Shortage Act. Concerns about laboratory personnel shortages, especially in rural areas prompted the Rural Health Coalition to introduce legislation to address the shortage issue.

H.R. 2405 introduced by Congressman Slattery and colleagues authorize a loan repayment program for medical technologies that agree to work in a rural area for a minimum of 2 years, and authorizes grants to schools for innovative outreach programs. ASCP supports these educational initiatives aimed at the rural needs.

This proposal in conjunction with the ASCP recommendations would meet the short- and long-term medical laboratory manpower needs. ASCP is greatly concerned and strongly opposes section IV of H.R. 2405, which establishes a proficiency examination for individuals who do not otherwise meet the educational requirements or other specific criteria established under the Clinical Laboratory Improvement Act of 1988.

We oppose the establishment of a proficiency example for many reasons. Past experience that is shown a Federal proficiency exam did not solve the problems of shortages, nor was it a good predictor of quality of future work of individuals who passed that examination.

Several studies were done by the Health Care Financing Administration and others on the effectiveness of this proficiency exam which was repealed by Congress in 1987. HCFA found less than 50 percent of those taking the exam passed.

The proficiency exam was not an adequate predictor of an individual's ability to perform specified laboratory efforts. Today's medical laboratory is a highly sophisticated environment. Tests are increasingly complex.

Therefore, the technologists who work there must be able to recognize the accuracies of the test results and proper instrument function among other responsibilities. All these functions require skill and judgment.

Education is basic to this. The majority of certified medical technologists in the field today have at a minimum an associate degree and most have a baccalaureate degree. Proficiency exam if implemented would devalue the credentials of those people and affect the compensation. That would hamper our retention.

It would also discourage other college educated people from entering the field in the future, hampering the field in the future, hampering our recruitment. For these reasons, ASCP strongly opposes proficiency exam mechanisms and would urge the subcommittee not to include it in title VII reauthorization.

In conclusion, ASCP urges the subcommittee to consider our educational initiative and to authorize grants to schools and programs training medical laboratory personnel.

True, Congress responded aggressively to the nursing shortage at its height. We believe today similar action is needed in this profession.

ASCP's educational initiatives and a loan repayment program and educational grant program of H.R. 2405 will provide mechanisms and meet both long- and short-term educational needs.

Mr. Chairman, the ASCP appreciates the opportunity to testify today.

I would be happy to answer any questions.

[The prepared statement of Mr. Snyder follows:]

PREPARED STATEMENT OF JOHN R. SNYDER, ON BEHALF OF THE AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS

Thank you Mr. Chairman. My name is John Snyder. I am the Director of the Division of Allied Health Sciences and Associate Dean, Indiana University School of Medicine. I am also a Medical Technologist certified by the American Society of Clinical Pathologists [ASCP]. I have been in practice for 20 years, serving in both rural and urban laboratory settings.

Today I am pleased to present testimony on behalf of ASCP. ASCP is a nonprofit medical specialty society with more than 50,000 members (with 39,000 laboratory personnel members and 11,000 pathologists). ASCP is also the largest certifying agency for medical laboratory personnel. Since 1928, ASCP has certified 300,000 medical technologists and other laboratory personnel.

Many of you are well aware of the extensive shortages of qualified medical laboratory personnel and its impact on laboratories, especially in rural and other traditionally underserved areas. In 1988 and again in 1990, the ASCP surveyed nearly 1,000 laboratory managers to determine the vacancy rates for 10 types of medical laboratory positions, including medical technologists, cytotechnologists, histotechnologists and medical laboratory technicians. ASCP estimates that in 1990, the nation's 12,000 hospital and independent laboratories had 41,950 unfilled positions. This compares to 24,800 unfilled positions in 1988. Cytotechnologist vacancies increased most dramatically since 1988, with one in four positions unfilled, a vacancy rate of 27.3 percent nationwide. The medical technologist vacancy rate of 11.6 percent exceeds the nursing vacancies of 11.3 percent experienced at the height of their shortage. Congress moved aggressively to solve the nursing shortage and similar action is needed for laboratory personnel.

Federal standards imposed under the Clinical Laboratory Improvement Amendments of 1988 [CLIA '88] to improve the quality of laboratory testing as well as the growth in the scope and complexity of clinical laboratory testing will further increase the need for trained laboratory personnel. One study indicates that without dramatic intervention and recruitment, vacancy rates for the clinical laboratory professionals will double by the year 2000.

While the decline in the applicant pool for medical laboratory education programs is of ten attributed to increasing opportunities for women in other medical fields and a general waning interest in health careers, two additional factors have strongly influenced the shortages of medical laboratory personnel. First, since 1981 there has been a significant erosion in hospital based educational programs in medical technology. The number of med tech programs decreased from 652 in 1980 to 420 in 1990 with almost 70 percent of these closed programs based in hospitals, the major source of medical technologists working in rural areas. Pressure on hospital based programs was compounded with the implementation of cost controls and Medicare's Prospective Payment System. Second, the decline in programs overall paralleled the termination of federal support for allied health education in 1981.

Current Allied Health Education Program

ASCP strongly supported and worked with this Subcommittee to reinstate the allied health programs in Title 7 of the Public Health Service Act. As you may be aware, Health Resources and Services Administration [HRSA] received 123 applications for special project grants under this program and approved almost 50 grants in the first year. However, only seven grants were funded. Almost half of the approved grants were from medical technology programs or allied health programs with a medical technology component, yet none was funded due to limited appropriations and priority given to professions engaged in geriatric care.

This year the allied health program received an appropriation at the authorization level of $2 million, but due to sequestration $1.7 million will be awarded to grantees. As published in the Federal Register, special consideration will be given to applicants from schools training professions engaged in geriatric care and those programs affiliated with community and migrant health centers. The current program is not addressing professions in short supply, such as medical laboratory personnel, that provide essential support services for geriatric care.

Recommendations

The key to addressing the shortages of medical laboratory personnel is to bring more candidates into the field through expanded educational programs. Therefore ASCP is pursuing a two pronged approach with the authorization and appropriations committees.

First, ASCP would like to see the current allied health program broadened to address the needs of allied health specialties experiencing the greatest national shortages, such as medical technology and cytotechnology. These professionals are critical to providing the support needed in geriatric care and in breast and cervical cancer screening, both high priority health programs. We urge you: (1) to reauthorize the allied health programs at current or increased levels; and (2) to incorporate language directing HHS to fund approved grants in shortage allied health professions as a high priority.

Second, the dimensions of the shortage problem require urgent focused action by the federal government. ASCP urges this Subcommittee to establish a special initiative in medical laboratory education, by authorizing grants to schools educating medical laboratory personnel as part of the reauthorization of Title 7, the Health Professions Education Act. Projects should include:

(1) Scholarships and/or stipends for medical technology, cytotechnology and histotechnology students for their clinical training period (3rd or 4th year of training) who agree to work in rural or other underserved hospitals. This would be the fastest way to increase the supply of laboratory professionals because existing schools have openings they cannot fill because of the lack of scholarship/stipend support.

(2) Grants to schools for consortium arrangements that creatively link academic resources with rural clinical settings to provide community-based education. Under this initiative, institutions of higher education could provide didactic instruction via

long-distance learning technologies and local clinical facilities could provide complimentary clinical instructions.

(3) Grants to schools to recruit nontraditional students into the fields of medical technology and cytotechnology. These grants could be used to set up customized programs to recruit and train nontraditional students such as minorities, midcareer science professionals (teachers), immigrants and graduating college students who have majored in science. These students may need 1 to 2 courses in addition to the clinical year of training, tutoring, or language support to enable them to work in a laboratory within an expedited time frame.

(4) Grants to schools to provide refresher courses for medical technologists and cytotechnologists who have not been working in the field for several years. Flexibility is necessary to establish programs to fit the individual needs of the medical technologist or cytotechnologist returning to the field.

(5) Grants to schools for recruiting and training medical laboratory technicians to become medical technologists. Stipends and/or scholarships to those technicians who agree to work in rural or underserved hospitals would be an added inducement for this personnel pool.

We are pleased that this initiative has been well received within the medical laboratory community and the following organizations have offered their support: American Society of Cytology, American Society for Medical Technology, American Association of Blood Banks, College of American Pathologists, American Society of Microbiology, American Society for Cytotechnology, American Cancer Society, Clinical Laboratory Management Association, American Association of Clinical Chemists and American Medical Association Committee on Allied Health Education and Accreditation. We are encouraged thus far and hope the Subcommittee will incorporate these proposals into legislation.

H.R. 2405—"The Rural Clinical Laboratory Personnel Shortage Act"

Concerns about laboratory personnel shortages, especially in rural areas, prompted the Rural Health Coalition to introduce legislation to address the shortage issue. H.R. 2405, introduced by Congressman Slattery and others, authorizes a loan repayment program for medical technologists that agree to work in a rural area for a minimum of two years and authorizes grants to schools for innovative outreach programs to train students in rural clinic settings and to train laboratory technicians to become technologists. ASCP supports these educational initiatives aimed at rural needs. This proposal, in conjunction with the ASCP recommendations, would meet the short and long term medical laboratory manpower needs.

ASCP is greatly concerned by, and strongly opposes, Section 4 of H.R. 2405 which establishes a proficiency exam for individuals who do not otherwise meet the educational requirements or other specific criteria established under the Clinical Laboratory Improvement Amendments of 1988. According to the bill, the exam would be administered within 180 days of enactment and annually thereafter until the Secretary develops a program to accredit public and private laboratory personnel certifying agencies.

We oppose the establishment of a proficiency exam for many reasons. Most importantly, past experience has shown us that a federal proficiency exam did not, solve problems of shortages nor was it a good predictor of the quality of the future work of individuals who pass the exam.

HHS developed and gave a proficiency exam from 1975-87 to qualify individuals as medical technologists to work in Medicare-approved laboratories. The authority for this exam was repealed by Congress in 1987. Several studies were done by the Health Care Financing Administration [HCFA] and others on the effectiveness of the exam. HCFA found that less than 50 percent of those taking the exam passed. With such a high failure rate the exam was not an effective means of addressing the shortage.

Second, the proficiency exam is not an adequate predictor of an individual's ability to perform specified laboratory tests accurately. In fact, studies have shown that ASCP certified technologists, who have completed college courses and formal training, outperform and make fewer errors than those without private sector certification. This study also showed that there was a positive correlation between the number of certified technologists and the accuracy of test results in the laboratory.

The impetus for CLIA '88 was Congressional concern that medical laboratory test results could not be trusted. Many Members of Congress had first hand experience with incorrect test results and poor overall quality. ASCP firmly believes that the laboratory and the services it provides is only as good as its professionals. College course work and formal training are necessary prerequisites for a medical technologist. The lab is highly computerized and tests are increasingly complex; therefore, technologists must be able to recognize the accuracy of test results and proper machine function among other responsibilities. All require skill and judgment, and education is basic to this.

The majority of certified medical technologists in the field today have completed the CLIA required college course work and more than 100,000 med techs practicing today hold a baccalaureate degree. The proficiency exam, if implemented, will devalue the credentials of these people, affect their compensation and discourage other college educated people from entering the field in the future. For these reasons, ASCP strongly opposes the proficiency exam mechanism and would urge the Subcommittee not to include it in the Title 7 reauthorization.

Conclusion

ASCP urges the Subcommittee to consider our educational initiative and to authorize grants to schools and programs training medical laboratory personnel. Congress responded aggressively to the nursing shortage at its height, and similar action is now needed for this profession. ASCP's educational initiatives and the loan repayment program and educational grant program in H.R. 2405 will provide the mechanisms to meet both short and long term educational needs. ASCP urges the subcommittee to forego the reestablishment of a proficiency exam. Its impact on the shortage will be minimal, yet its potential to expose patients to the risks of inaccurate testing may be great.

Mr. BRUCE. Thank you, Dr. Snyder.

Now we will hear from Dr. Rosenfield.

STATEMENT OF ALLAN ROSENFIELD

Mr. ROSENFIELD. Thank you, Mr. Bruce, Mr. Towns.

I am Allan Rosenfield from Columbia. I am representing today the Association of Schools of Public Health. My colleagues and I appreciate the opportunity to testify on the contributions of academic public health in promoting health and preventing disease in this Nation.

In general, to justify continued Federal support to the 24 schools of public health in the United States. The Nation set for itself the year 2000 objectives for promoting health and preventing disease throughout the United States.

Winning those objectives will depend on effective leadership of health agencies at national, State and local levels. These agencies in turn must rely on the university graduate schools of public health and other public health preventive medicine programs to provide the leadership in the form of comprehensively trained public health professionals, now in short supply.

Too few physicians and other professionals who are urgently needed as comprehensively trained professional leaders are reluctant to undergo such training when they enter the field of public health. According to Secretary Sullivan, there are serious shortages of epidemiologists, nutritionists and nurses with degrees from schools of public health.

If we are to address the year 2000 objectives, the situation calls for vigorous recruitment of students by schools of public heath and accredited preventive medicine programs as well as the production of greater numbers of comprehensively trained public health careerists in the areas of critical personnel shortages.

The 24 schools of public health, in 18 States and Puerto Rico, constitute a primary source of comprehensively trained public health professionals to serve the Federal Government, the 50 States and the private sector. To meet the inevitably growing demands of the year 2000 objectives for leaders with comprehensive training, the schools must be able to fund the costs for, one, recruiting and financially assisting students as needed; two, strengthening and expanding teaching programs especially in areas of extreme urgency such as AIDS prevention and control, substance abuse, injuries, teen pregnancy, maternal and child health care availability and access, quality and cost, health needs of the elderly and environmental and occupational and health hazards; and three, linking faculty and students with operating public health agencies.

Mr. Chairman, in their contributing role as producers of leaders in the Nation's health system, the schools of public health have been linked to the U.S. military academies. No one has questioned the often repeated assertion that, if the graduate schools of public health did not exist, the Federal Government would have to establish a national academy of public health.

With disease prevention and health promotions as their primary goals, schools of public health and the graduates approach health problems on a broad front. This is illustrated, for example, by the many-faceted attack on AIDS, which involves not only intensive laboratory and field research aimed at developing means of prevention and cure, but also educational, political, legal, ethical, economic and care providing activities that are essential to containment of the epidemic and demonstration of human concern.

Public health school graduates bring to the year 2000 objectives the broad view, knowledge and skills acquired in studying the full range of health problems afflicting the U.S. population. Our graduates are prepared to organize and direct concerted efforts by health professionals, professionals, public health and private agencies, institutions and community organizations to further the year 2000 objectives. They are prepared to organize and direct concerted efforts by health professionals, public and private agencies, institutions and community organizations to further year 2000 objectives.

Mr. Chairman, continued Federal support of the schools can be justified as an investment in the infrastructure that produces comprehensively trained public health professionals needed to meet the year 2000 objectives.

I have attached to my testimony a proposal by the Association of Schools of Public Health that outline the means for the Federal Government to share with the schools of public health responsibility for furthering the year 2000 objectives by providing adequate leadership for the undertaking. The year 2000 objectives demand the highly trained, top level personnel and effective State and local health agencies makes it imperative that schools of public health be enabled to forge strong links with operating agencies.

Our proposal for targeted grants would enhance public health students training through practical field experience akin to hospital training of medical students. It would provide much needed faculty consultation of policy and procedural problems of agencies and institutions.

The 24 accredited graduate schools of public health can document the need for Federal funding to enable them to strengthen faculties and mount new and expanded teaching programs to help assure the production of adequately prepared leadership in sufficient supply to meet the challenges highlighted by the year 2000 objectives.

In summary, the will to meet the year 2000 objectives is present in the schools of public health and in the pool of perspective students. Funds are insufficient. Our graduates do not make a great deal of money.

In addition to the funding needs of schools for direct costs, support services and expenses in teaching programs to accommodate increased enrollment, successful recruitment of minorities and trained professionals would require financial support as well. Our proposal addresses those needs.

Thank you for giving the U.S. academic public health community the opportunity to express its views of continued Federal support to the field.

Your thoughtful consideration of our proposal as you and the subcommittee draft a new health profession, education and training bill will be greatly appreciated.

[The attachment referred to follows:]

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ASPH REAUTHORIZATION
FACT SHEET

Contact: Mike Gemmell

FURTHERING YEAR 2000 OBJECTIVES BY FEDERAL GRANTS TO SCHOOLS OF PUBLIC HEALTH

The public health training provisions in Title VII of the Public Health Service Act (the "Health Professions Reauthorization Act of 1988") expires September 30, 1991. Congress began supporting higher education in 1865 when it passed the Morrill land-grant college bill; almost a century later it passed the second oldest higher education support program, "The Hill-Rhodes Act of 1958". It authorized the "surgeon general to make certain grants-in-aid for the support of public or non-profit educational institutions which provide training and services in the fields of public health."

The eleven schools of public health then and the 24 schools now are "essentially national schools", since students come from the 50 states, Puerto Rico and from the U.S. related territories. Graduates of these schools then and now (over 3,500 this year) serve primarily in the public and non-profit sector. Over 80 percent of the graduates work in government agencies, universities or for non-profit health organizations. As such, these schools take on the characteristic of "service academies". In fact, the "West Point(s) of Health" was the term applied to the schools of public health in 1958 when President Eisenhower signed the Hill-Rhodes bill. In that bipartisan landmark legislation, **Congress recognized specialized training of professional public health leaders for public service as a federal responsibility to be shared with the schools**. Indeed, it was noted that, had not the schools already existed as an essential federal resource, the health equivalent of a service academy would have had to be created. "Hill-Rhodes" authorized funds to train professionals to fill the 30 percent vacant health officer positions in 1958. It also authorized funds to meet the "demand for research workers" as "Congress has recognized the need and has increased appropriations for public health research. The present and prospective output of the schools of public health cannot meet these many demands without assistance.*" Similar demands are facing the schools and the nation today.

The need for public health professionals in the 1990s could be double the 1980 level, a 1988 HHS report to Congress indicates. The need for professionals has increased with the proliferation of health programs and agencies. In numerous reports to the President and Congress, HHS pointed to shortages of epidemiologists, environmental health professionals, toxicologists, biostatisticians, nutritionists, public health nurses, and physicians trained in public health and preventive medicine.

Yet federal health officials have committed the nation to the achievement of over 200 objectives for promoting health and preventing disease by the year 2000. Attaining those objectives will depend on effective leadership of health organizations and agencies at national, state and local levels. These agencies, in turn, must rely on the university graduate schools of public health to provide such leadership in the form of comprehensively-trained public health professionals now in short supply. While personnel increases will be necessary in all categories of the public health work force, the most critical need will be for physicians, biological and behavioral scientists, engineers, administrators and other professionals who have been prepared in schools of public health to play much larger and more challenging roles than those for which they were basically trained in their respective professions.

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* January 29, 1958 hearing on H.R. 6771, a bill to authorize support for schools of public health

The schools of public health in 18 states and Puerto Rico constitute a source of comprehensively-trained public health professionals to serve the federal government, the 50 states and the private sector. All of the many disciplines relevant to public health are represented on these schools' faculties, familiarizing students with today's array of major health problems and the multidisciplinary approach required for their solution. To meet the inevitably growing demands of the Year 2000 Objectives for leaders with the comprehensive training that schools of public health provide, the schools must be enabled to fund (1) the costs of recruiting and financially assisting students as needed, and (2) to convey a part of the costs of strengthening and expanding their teaching programs, especially in areas of extreme urgency, such as AIDS, substance abuse, injuries, maternal and child health, health care availability, quality and costs, health needs of the elderly and environmental and occupational health hazards.

The following proposal by the Association of Schools of Public Health (ASPH) outlines a means for the federal government to share with the schools of public health responsibility of furthering the Year 2000 Objectives by providing adequate leadership for the undertaking.

SPECIAL PROJECTS

It is proposed that Part F (Special Projects) of Title VII (42 U.S.C. 295f-2 et seq.) of the PHS Act be amended to delete present language from Section 780A and to substitute new language authorizing the Secretary to make grants to accredited schools of public health in the interest of accomplishing the Year 2000 Objectives. Such grants would enable the schools to:

(1) Provide graduate students with comprehensive knowledge and skills required for them to work effectively toward attainment of Year 2000 Objectives.

(2) Recruit candidates for graduate education in preparation for public service in specialties that are in short supply and necessary to accomplish the Year 2000 Objectives.

(3) Increase enrollment of minority and disadvantaged students for comprehensive graduate training leading to public health professional careers contributing with special importance to achieving the Year 2000 Objectives.

(4) Strengthen existing departments of instruction, specialized teaching programs and curricula and develop, as needed, new departments, specialized teaching programs and courses to prepare students, as public health professionals, to cope with specific, especially severe health problems targeted in the Year 2000 Objectives.

(5) Strengthen and extend continuing education, non-degree teaching programs, to public health officials in the field, both locally and regionally, in furtherance of the Year 2000 Objectives.

(6) Strengthen and expand teaching programs, as needed for part-time degree candidates, including those who are employed full-time and need such special provisions as evening, weekend and summer courses.

(7) Establish firm links with governmental and private health agencies and institutions as sites for field practice training of students and for faculty consultative services to the cooperating agencies and institutions upon whose effectiveness success of the Year 2000 Objectives campaign will depend heavily.

(8) Improve access to preventive services and other community-based programs.

For purposes of carrying out Section 790A as reworded, it is proposed that there be authorized to be appropriated $10 million for fiscal year 1992, $15 million for fiscal year 1993, and $20 million for fiscal year 1994.

TRAINEESHIPS

It is proposed that Sec. 792 (Traineeships) of Title VII of the PHS Act be renewed with amendments increasing the amounts authorized for appropriations under the authority of the Secretary to make grants to accredited schools of public health to provide traineeships for increasing numbers of graduate students preparing to serve the Year 2000 Objectives, particularly students representing disciplines and specialties in short supply. Such traineeships would be awarded primarily to students in the following categories:

(1) Minority and disadvantages students.

(2) Physicians, scientists and engineers who are in extremely short supply in the public health field.

(3) Students in other areas of severe personnel shortage including epidemiology, biostatistics, preventive medicine, public health dentistry, public health nutrition, public health nursing and environmental and occupational health specialties such as in toxicology and chemistry.

(4) Students in specialized training in such areas as maternal and child health, AIDS prevention and control, drug abuse, infant mortality, injury prevention and control, toxic wastes, chronic disease prevention and control, health problems in minority populations, health problems of the elderly, migrants and immigrants, health care access, quality and cost of medical care, and the need for effective health promotion programs in urban and rural areas.

For purposes of carrying out Section 792 as amended, it is proposed that there be authorized to be appropriated $10 million for fiscal year 1992, $15 million for fiscal 1993, and $20 million for fiscal year 1994.

PREVENTIVE MEDICINE RESIDENCIES

It is proposed that Sec. 788 (c) of Title VII, PHS Act, be renewed to continue federal support for preventive medicine residency (PMRs) programs. According to HHS, shortages or physicians trained in public and preventive medicine exist. The 1980 report of the HHS Graduate Medical Education National Advisory Committee (GMENAC) projected a shortfall in supply of preventive medicine specialists of 25 percent by 1990. In 1988 the HHS Council on Graduate Medical Education validated this assessment. In his 1990 report on the status of U.S. health personnel, Secretary Sullivan affirmed a shortage of public and community health personnel, including physicians trained in public and preventive medicine. At the same time, meeting the Year 2000 Objectives will require a substantial number of personnel trained to provide health promotion and disease prevention services.

For the purpose of carrying out Section 788 (c), it is proposed that there be authorized to be appropriated $5 million for fiscal year 1992, $7 million for fiscal year 1993 and $10 million for fiscal year 1994.

HCOP

It is proposed that Sec. 787, PHS Act, be renewed to continue federal support for the Health Careers Opportunity Program (HCOP). HCOP serves as the principal federal health training activity for underrepresented minorities and other students who are financially or otherwise disadvantaged. According to HHS, there is an increased demand and need for well-trained minority public health professionals. Preliminary and enrichment education have proven to be successful in removing the barriers that have caused the persistent underrepresentation of minorities in public health. Increased HCOP funding will make available additional dollars for support services to prepare students to successfully compete for entry into and graduation from schools of public health in order to address the national health needs of the nation (Year 2000 Health Objectives).

For the purpose of carrying out Section 787, it is proposed that there be authorized to be appropriated $40 million for fiscal year 1992, $42 million for fiscal year 1993, and $45 million for fiscal year 1994.

PREVENTION CENTERS

It is proposed that Sec. 1706 of Title XVII, PHS Act, be renewed to continue federal support for the CDC prevention centers grant program. Initiated in 1986, seven centers are currently funded. They are conducting research that focuses on ways to promote health and prevent disease. Each center works closely with local health agencies as well as with providers of health services to develop new ways of promoting health and on improved methods of appraising health hazards and risk factors. In short, they are developing state-of-the-art prevention techniques. Located in the multi-disciplinary schools of public health, the centers serve as demonstration sites for translating new knowledge into practice.

For purposes of carrying out Section 1706, it is proposed that there be authorized to be appropriated $10 million for fiscal year 1992, $11 million for fiscal year 1993 and $13 million for fiscal year 1994.

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Mr. **Bruce**. Thank you, Dr. Rosenfield. We will now hear from Dr. Patricia L. Ewalt. She is accompanied by Dr. Frank B. Raymond, President of the National Association of Deans, Director of Schools of Social Work.

Doctor, happy to have Dr. Raymond with us also.

STATEMENT OF PATRICIA L. EWALT

Ms. **Ewalt**. Thank you very much.

Good afternoon, Mr. Bruce and Mr. Towns.

My name is Patricia Ewalt, dean of the school of social work at the University of Hawaii and as our chairman said, I am accompanied by Dean Frank Raymond, who is our national president of the Deans and Director of Schools of Social Work.

I am representing here today both the deans and directors and the National Association of Social Workers.

The deans and directors in turn represent graduate programs of social work in nearly every State as well as the District of Columbia and Puerto Rico. NASW represents 135,000 members nationally.

My objective today is to encourage you to recognize social work as a health profession in title VII, so that graduate programs of social workers eligible to compete for appropriate research and training opportunities. Schools of social work are currently identified in only one section of title VII to support graduate education and health administration, hospital administration and health planning.

During the reauthorization of title VII in 1988, social work was not defined as a health profession, as an allied health profession. Therefore, social workers are identified as neither members of allied health professions nor as a health professional.

I would like to explain why social work should be recognized as a health profession in title VII. Too often the profession is still regarded as restricted to roles in public assistance.

While many of our members do practice in public assistance and child welfare, social worker encompasses many other specialities. I might mention at this time our pride in Mr. Towns who is a professional social worker. We are very pleased that he is on this committee and in the Congress.

Social workers have, in fact, been involved in health care since before the turn of the century. The Massachusetts General Hospital in Boston hired its first medical social worker in 1905.

Today most, I would say practically all major hospitals have departments of social work. Social workers perform, for example, preadmission planning.

They assess the social and emotional factors that contribute to the patient's condition and that may interfere with the plan of treatment. They do discharge planning to facilitate effective after care.

They do financial counseling, community health education and they lead support groups related to such problems as cancer, AIDS, head injury, cardiac problems and stroke education.

In 1987, surgeon William DeVries, who implanted the first artificial heart, said social work is absolutely critical to medical success of heart transplantation and heart implementation. Social work assessment is critical in screening patients to determine whether the individual is equipped to comply with the rigorous regiment and whether the individual has a good family support system and an understanding of the process.

We found the social work stage in whether we would accept a patient or not, is every bit as critical for well being as any medical stake. The same is true for any type of transplantation.

Social work role in primary health care is not restricted to the hospital. It goes to health centers, home health agencies, rehabilitation facilities, hospices, prenatal and perinatal programs.

These are, for instance, standards established by NASW for practice in various health settings.

Examples of the benefits of social work intervention in home health care include the following: Early social work assessment and intervention in home health, expedite shorter periods of skilled nursing and other medical services.

Social work services increases the patient's ability to stay at home, thus preventing rehospitalization. Social work services stabilize the care giver system and additionally promote recovery in the home. Social work services prevent costly crisis reaction by the patient and by the support system.

Clinical social work is, in fact, the single largest professional provided mental health care in the United States. The profession is a licensed health care profession in both Medicare and Medicaid.

Clinical social workers are recognized as independent providers of outpatient medical health care in all Federal health insurance programs, including FEHB, Medicare and CHAMUS.

The inclusion of social workers in the identified health profession within the title VII programs is of great importance to social work education.

Currently, schools of social work are severely limited in applying for title VII program funding opportunities, if not outright ineligible. I might mention that there are very fine medical schools in both of your districts, and they are ineligible, of course, for these programs.

We feel the social work profession is at a distinct disadvantage. Social workers are on the faculty of medical schools throughout the country, yet we are unable to compete for health educational opportunities to train our own students.

My Senator, Senator Inouye, has been instrumental in recognizing the profession's role in health and mental health care delivery. Through his leadership, schools of social workers are eligible to participate in the interdisciplinary rural health training position of HRSA.

I might say our own school received one of those grants. Schools of social work are eligible to apply for funds to assist disadvantaged students through HCOP, pertaining to the Indian Health Service.

I ask your help in extending this recognition to appropriate title VII programs of the Public Health Service Act.

Thank you very much for inviting us to testify.

[The prepared statement of Ms. Ewalt follows:]

Prepared Statement of Patricia L. Ewalt, on Behalf of the National Association of Social Workers and the National Association of Deans and Directors of Schools of Social Work

Good Morning. My name is Patricia Ewalt. I am Dean of the School of Social Work at the University of Hawaii at Manoa. I am here today on behalf of the National Association of Social Workers [NASW] and the National Association of Deans and Directors of Schools of Social Work. NASW represents 135,000 professional social workers nationwide, two-thirds of whom practice in health and mental health care settings.

My objective today is to encourage you to recognize social work as a health profession in selected Title VII programs so that graduate schools of social work are eligible to compete for appropriate research and training opportunities.

First, I would like to provide some information on the social work profession's role in primary health and mental health care delivery. Too often, I believe, the profession is still popularly regarded as restricted to roles in public assistance. While many members of the profession do practice in public assistance and child welfare programs, social work fields of practice encompass many other specialties.

Social workers have been involved in the health care field since before the turn of the century. In fact, Massachusetts General Hospital in Boston hired its first medical social worker in 1905. Today, most major hospitals have Departments of Social Work. Social workers perform such functions as: preadmission planning; assessment of social and emotional factors that contribute to the patient's condition and may interface with the plan of treatment and recovery; discharge planning to facilitate effective aftercare; illness adjustment and management counseling; financial counseling; patient and family advocacy; and patient and family conferences. In addition, hospital social workers are often involved in community health education and promotion activities and lead support groups related to cancer, AIDS, head injury, cardiac problems and stroke education.

In 1987, surgeon William DeVries, who implanted the first artificial hearts, said, "Social work is absolutely critical to the medical success of heart transplantation and heart implementation." With these extremely delicate and complicated procedures, social work assessment is critical in screening patients to determine whether the individual is equipped to comply with the rigorous regimen that patients must follow once the surgery is completed and whether the individual has a good family support system and an understanding of the process. In addition, the social worker works with the patient and family during the stressful waiting period for an appropriate donor. "We found the social work stake in whether we would accept a patient or not was every bit as critical for well-being is any medical stake," said Dr. DeVries.

Social work's role in primary health care is not restricted to the hospital. Social workers practice in virtually every type of health care setting including community health centers, health maintenance organizations, home health agencies, rehabilitation facilities, hospices, prenatal and perinatal programs, etc.

I'd like to provide one example of how the Health Care Financing Administration defines the role of social work in home health, a condition of participation in the Medicare home health program.

"The social worker assists the physician and other team members in understanding the significant social and emotional factors related to the health problems, participates in the development of the plan of treatment, prepares clinical and progress notes, works with the family, utilizes appropriate community resources, participates in discharge planning and inservice programs, and acts as a consultant to other agency personnel." (42 CFR, section 405.1226)

In home health care, social work functions include, but are not limited to:

(1) Skilled assessment of the social, economic, environmental and psychoemotional factors related to the patient's illness, need for care, response to treatment and adjustment to care; followed by care plan development.

(2) Counseling for long-range planning and decisionmaking, including: assessment of the patient's needs for long-term care, evaluation of the home and family situation, enabling patient and family to develop an in-home care system, exploring alternatives to in-home care, when needed, and arrangement for placement.

(3) Community resource planning, including education, advocacy, referral and linkage to community services.

(4) Short-term therapy or goal-oriented intervention directed toward: management of terminal illness, reaction and adjustment to illness, strengthening the family support system, and conflict resolution related to the chronicity of illness.

(5) Crisis intervention and problem resolution associated with high risk indicators endangering a patient's mental and physical health, such as: abuse and neglect, inadequate food or medical supplies, high suicidal potential, or an unsafe environment.

The benefits of social work intervention in home health care include the following:

(1) Data suggests that early social work assessment and intervention in home care expedite shorter periods of skilled nursing and other medical services.

(2) Social work services that address the social and emotional problems which negatively the patient's response to treatment increase the patient's ability to stay at home, thus preventing rehospitalization or other costly institutionalization.

(3) Social work services that strengthen the family and other support systems, as well as provide a linkage to needed community resources, stabilize the caregiver system and additionally promote recovery in the home.

(4) Social work services that promote long-term planning allow the patient to continue to act on his or her own behalf, consequently preventing or reducing costly "crisis reactions" by the patient and support system.

Today, clinical social work is the single largest profession providing mental heath care in the U.S. The profession is legally regulated in all but one state, and is identified as a "licensed health care profession" in both the Medicare and Medicaid statutes. Additionally, clinical social workers are recognized as independent providers of outpatient mental health care in all federal health insurance programs (Medicare, the Federal Employees Health Benefits Program, and the Civilian Health and Medical Program of the Uniformed Services).

Despite the profession's historical role in health care delivery, few opportunities exist for training social workers through federal training programs for the health professions. The exception is the National Institute of Mental Health's Clinical Training Program which is currently funded at $13.7 million and provides assistance to five mental health professions, including clinical social work.

Renewed attention has been directed toward the need to provide training opportunities for social workers in health care during recent years. The President's Commission on the Human Immunodeficiency Virus [HIV] Epidemic and the 1990 Senate Appropriations Report urged that scholarships be made available through the National Health Service Corps [NHSC] Program to train medical social workers for service in HIV-endemic areas.

Schools of social work, however, are currently identified in only one section of Title VII. Section 791(2) authorizes funding for different entities, including schools of social work, to support graduate education in health administration, hospital administration and health planning.

During reauthorization of the Title VII programs through the 1988 Health Professions Reauthorization Act (P.L. 100-607), an individual with a degree in social work was added to the list of health professionals that are not considered to be an allied health professional. However, social work was not defined as a heath profession for purposes of Title VII program opportunities.

Accordingly, professional social workers are identified as neither members of the allied health profession nor a health profession for purposes of the Title VII health training opportunities.

The inclusion of social work as an identified health profession within the Title VII programs is of great importance to social work education. Currently, schools of social work are severely limited in applying for Title VII program funding opportunities, if not outright ineligible. For example, schools of social work are not defined as health professional schools in eligibility criteria for NIH Biomedical Research Support Grants. This is true even though schools may meet all other criteria because social work is not in the basic Public Health Service definition.

Some programs authorized through Title VII, such as the Health Careers Opportunity Program, allow more flexibility in funding opportunities. However, given budget constraints, schools which are not identified as training the specified health professions or allied health professionals are rarely granted funding support.

In addition, the PHS Act is often used as the base for new legislative initiatives in the training of health professions. Social work is generally omitted from consideration in the new initiatives because it is not identified in the PHS Act.

Mr. Chairman, we feel that the social work profession is at a distinct disadvantage. Professional social workers are on the faculty of various medical schools throughout the country. Yet, we are unable to compete for available health educational opportunities to train our own students.

My Senator, Senator Inouye, has been instrumental in recognizing the profession's role in health and mental health care delivery. Through his leadership, schools of social work are now eligible to participate in the Interdisciplinary Rural Health Training Initiative of the Health Resources and Services Administration. And schools of social work are eligible to apply for funds to assist disadvantaged students through the Health Careers Opportunity Program of the Indian Health Service.

I ask your help in extending this recognition to appropriate Title VII programs of the Public Health Service Act. Specifically, we seek your help in: Adding a "graduate program in social work" to the definitions in section 701 (4) and (5); adding "social workers" to the list of providers for whom the Secretary collects health professions data in section 708(a); adding "social work" to the list of schools in which students may be enrolled for eligibility for federal loan assistance in section 729(a); adding "schools of social work" to the list of eligible schools whose disadvantaged students may apply for assistance [HCOP] in section 787(a)(1); and adding "social work" to the list of schools which may receive support for projects which teach health professions students to provide for the health care needs of individuals with AIDS in section 788B(a)(1).

Thank you for the opportunity to present this testimony before the Subcommittee.

Mr. **Bruce**. We appreciate your testimony. I understand Dr. Rosenfield, you have to catch a plane and need to be excused if we can.

Mr. Towns, do you have a question for Dr. Rosenfield?

Mr. **Towns**. No. I would like to as you to yield for unanimous consent request to include my statement in the record. I was not here at the opening this morning.

Mr. **Bruce**. Should I mention you were a professional social worker before you got here?

Mr. **Towns**. No question about it.

May I add a good one.

Mr. **Bruce**. It will be included in the record.

[The prepared statement of Mr. Towns follows:]

Prepared Statement of Hon. Ed Towns

Mr. Chairman, I am very pleased that the subcommittee will have an opportunity to hear testimony today in preparation for the reauthorization of title VII, Health Manpower Programs, and title VIII, Nursing Education Programs, of the Public Health Service Act.

New York City has specific concerns in at least two areas, discrimination against foreign medical graduates and transition in nursing careers, which I hope we can address in the reauthorization process. A number of our city's hospitals are heavily staffed by international medical graduates. During the subcommittee's last consideration of title VII, a GAO report was requested to investigate the issue of discrimination faced by IMGs. That report entitled "Medical Licensing by Endorsement: requirements Differ for Graduates of Foreign and U.S. Medical Schools" recommended that a clearinghouse for medical credentials be established in order to streamline the process of State-to-State licensing. Legislation introduced by Congressman Mervyn Dymally and myself would create just such a national clearinghouse with oversight by the Secretary of HHS. I am pleased to see that Congressman Steve Solarz who is a well-known advocate in this area will also be testifying today on the IMG issue.

Second, Mr. Chairman, the greater New York Hospital Association has developed a successful transition education program designed to ease New York's nursing shortage. This program which is called Project LINC, for "Ladders in Nursing Careers," provides hospital employees their full-time salary while working at the hospital part-time and studying for an LPN or RN degree. In just 2 years, the program has graduated 96 participants. A total of 130 will have graduated by the end of this year. Despite this success, LINC has been unable to receive funding under the special grant provisions of title VIII.

Mr. Chairman, I would like to submit two articles on the above issues for the record and I hope that concerns I have raised here today can be addressed during reauthorization.

Mr. **Bruce**. Dr. Rosenfield, we appreciate your testimony. We will let you get on your airplane.

Mr. Rosenfield. Thank you very much, Mr. Chairman.

Mr. Bruce. I was just going through all the figures and including by implication Dr. Ewalt, we will put you in the health professions here for today's discussion by order of the chairman.

There is a shortage of physical therapists, occupational therapists, speech language therapists, medical technologists, cytotechnologists. There are six physical therapy jobs for every one person. Hospitals have had to close emergency rooms, intensive care beds.

Forty-eight percent of hospitals have difficult recruiting allied health professions. Twenty-five percent have trouble retaining those that we have.

The VA hospital, one in my district, in fact, reports a vacancy rate of 26 percent for physical therapists and 19 percent for occupational therapists. We need an 87 percent increased in most of the allied health professions by the year 2000.

Given all those facts, can you explain to me what we are doing wrong when the entire Federal Government puts forward $700,000 in 1989 and $1.4 million for special projects for allied health care professionals?

What is it that you and I are doing wrong? I would just like to have, starting with Mr. Selker and Mr. Snyder and Dr. Ewalt, all of you give me some idea why it is.

When we had a nurse shortage nationwide, State legislative bodies, the U.S. Congress all kind of joined together. We have a tendency, I think to have a larger crisis, but it is not perceived as a crisis.

Dr. Selker?

Mr. Selker. Thank you.

First of all, the very first thing that strikes me is there is, it seems there is no way we could have a common understanding of the problem and still arrive at those kinds of numbers in terms of support. That obviously has to be a major barrier.

I think a second reason for why we are confronted with this circumstance is because the allied health professions are by definition a diverse, multidisciplinary group, it has historically been a group that has been harder to understand. I think it was DeGaulle who said about the French people and people with over 100 types of cheese are impossible to govern.

In some ways this is the way it is with the allied health professions as well. Because we have such poor data on the allied health professions and because the group is so diverse, it is also very difficult to create a common understanding of the problem as we were able to do with the nursing shortage and with some of the other shortages that confronted us.

In terms of addressing the problem, once again, the faculty shortage appears to be a major contributor. In a lot of data you have just referred to, taking physical therapy as one example, the physical therapy faculty work with small numbers of students, transmitting to them the hands-on kinds of skills that they have to know to give quality patient care.

There is no way that small group can be put in an amphitheater with 600 to 800 students. So we can't just automatically turn up the crank in terms of producing physical therapists.

The need for additional faculty would allow us to expand enrollments. That is only part of the picture. We have to make the academic environment more congenial to allied health professions as well.

Allied health professionals are, relatively speaking, new comers to major research universities and yet are expected to compete with the more traditional disciplines and basic sciences in terms of research accomplishments and major accomplishments to their body of knowledge.

One of the things we are experiencing in our physical therapy department, for example, we have a dozen physical therapists who are winning at the National Science Foundation, which is unheard of, who are winning at NIH.

But they don't have the traditional support structure that basic science faculty have where there is a small cadre of pre- and postdoctoral individuals, fellows who can support the research effort. We have this one group of very capable academic researchers who are at an extraordinarily risk for burn out.

Then we have another subpopulation of academic faculty who need more work in terms of faculty development and training in how to do research, how to contribute to the knowledge base within the respective allied health disciplines, how to do health services research within the respective allied health disciplines to determine if their disciplines are efficacious and are of high quality.

As I say, it is a complex problem. Probably the root of it is the diversity of the allied health professions make it more difficult to create a common understanding of the problem.

Mr. **Bruce**. Dr. Snyder?

Mr. **Snyder**. Thank you.

I would add one more piece. Virtually all allied health programs rely on a close partnership with a health care facility.

The clinical education component is clinical. There are limited spaces available to do that kind of education.

For the medical laboratory community we basically have two problems that I would point to. There has been a declining number of students who are choosing the medical laboratory area as a career field for a variety of reasons.

Some of it has to do with our image problem. I frequently go to high schools and talk to high school students saying there are careers in allied health.

"I am a medical technologist; do you know what I do?"

No idea. They think I ride in an ambulance or I work with computers.

Clinical laboratory is not part of that. Even though many of them as I talk to them have an interest in the laboratories that they are doing experiments in high school, and I say, "But, that is my job in health care. You can be one, too."

So part of it is image problem and recruitment to the profession.

The second is a decrease in the number of programs of educational programs. They are shrinking more in the hospital-based educational programs. These are programs sponsored by hospitals the senior year of a baccalaureate degree.

These have primarily been in rural settings. I am a product of a medical technology program that was hospital based in a community of 5,000, a good quality program.

I was happy to serve, happy to work in that community afterward. That program fortunately is one of the 400 and some that exist today, but we have lost 200 to 300 of these kinds of programs. That is what is drawing back on our shortages.

The answers we have talked about today. We have talked about ways to deal with recruitment. We have talked about scholarships and stipends and so forth.

Congressman Slattery's bill has worked to address that as well as the other initiatives I have mentioned from ASCP. We have talked about innovative ways of delivering education, long distance technology.

I was pleased to hear the nursing group was talking about beaming courses out. Maybe we need to beam those courses to those rural hospitals from the academic health centers like the UFI at Chicago.

We also need to talk about curricula that can accommodate students who are today a nontraditional variety. It may mean doing some evening classes instead of a straight 8 to 5 Monday through Friday curriculum.

These are working parents sometimes, people that are willing to shift careers. These are part of the answers to all this.

Mr. **Bruce**. Thank you.

Dr. Ewalt?

Ms. **Ewalt**. Thank you.

The graduate programs of social work turn out about 4,000 health related graduates in health and mental health in a year. In our school over the last 4 years we have more than doubled the number of graduates. There is still a shortage.

I think the public does not recognize that there is a shortage until the shortage affects them or their families. They think in health in general, I think that the problems are going to happen to somebody else until it happens to them.

Until it becomes a public issue, it is very hard for people to recognize the magnitude of the problem. Congress has these figures available, but the people don't seem to understand until it becomes a public issue.

In our State it is a public issue. It is in the paper at least weekly about the social work shortage. So people can come to understand when it does affect them and they don't have a social worker to see to their relatives or themselves when they have either an acute or long-term problem.

Mr. **Bruce**. How do you bump that on the front pages or at least into the papers of your Hawaiian papers?

What did you do to get that issue brought to the public?

Ms. **Ewalt**. Two ways: One is the negative way. It became so serious that there weren't enough social workers to go around. There were a couple of court cases, and it was because overwork of the social workers that were on the job and couldn't cover 80 cases or 40 cases or whatever it was in their line of work.

There was trouble, as so often it takes some disaster to bring it to our attention.

The more positive side is the increase in legislators paying attention to that and the public is, too. You double the program and offer the program in all four of our major islands and do it at night as well as the day, people do appreciate that. That takes resources.

It takes, perhaps, trouble on the bad side and it also takes some creative responsiveness. That does take some money.

May Dean Raymond also add to that?

Mr. **Bruce**. I was going to ask the very question of Dean Raymond, if he had anything to add to this question of how do we bring to the attention of the public the shortage and mobilize the various allied professions to do that so that Congress will respond with additional funding.

Mr. **Raymond**. I think one way is to call to the public's attention the change of demographics and the impact this will have on the various health professions. The Department of Labor estimated by the year 2000 there will be a need for 700,000 geriatric workers.

Many of these rolls will involve the health professions. The services they will be providing will be in the area of the health field.

In the field of social work the need for more medical social workers is going to increase dramatically. There are also, there is also going to be an increase of social workers in other areas besides just medical care, of course.

I think the number of social workers involved in the health field has not been recognized. As was pointed out earlier, approximately two thirds of our graduates do good to work in the areas of health and mental health field.

This is going to continue to grow. We must bring this to the public's attention by calling attention to the changing demographics and the roles our professions play and to the fact there are professions such as social work that make for a more efficacious health system.

It has been demonstrated through research that the provision of social services in a health setting does reduce costs. I think these kinds of facts before the public will help draw attention to the concerns we are addressing.

Mr. **Bruce**. I thank the panel for your testimony and response to the questions.

With no other business coming before this committee this afternoon, we stand adjourned.

[Whereupon, at 3 p.m., the subcommittee adjourned.]

[The following material was submitted for the record:]

American Academy of Pediatrics

The American Academy of Pediatrics, the Ambulatory Pediatric Association, and the Association of Medical School Pediatric Department Chairmen submit this statement for the record of the hearing held May 30, 1991, regarding Titles VII and VIII of the Public Health Service Act, programs which provide financial support critical to health professions training. Our organizations represent office- and hospital-based practicing pediatricians, full-time academic and clinical faculty responsible for the training of pediatricians, and the leadership of medical school pediatric departments.

Our organizations are concerned about maintaining the necessary supply of general pediatricians who have been trained to care for the special needs of infants, children, and adolescents. The Academy is working with the American Medical Students Association and the Student National Medical Association to demonstrate to medical students the challenges and opportunities of pediatrics. It is also examining other options for promoting pediatrics to medical students.

The Primary Care Training Grant for General Internal Medicine and General Pediatrics program is a small, but crucial, source of funding for the training of primary care pediatricians. To eliminate this program could mean a reduction in the number of pediatric residents. It would, however, affect the nature of the training in many institutions and remove some out-of-hospital training sites now used.

BACKGROUND

Section 784 of the Health Professions Training Assistance Act of 1986 authorizes grants by the federal government administered through the Bureau of Health Professions, HRSA, of the Public Health Service for residency training in general internal medicine or general pediatrics. This program was started in the mid-seventies as the answer to a perceived need to increase the supply of primary care physicians. This program was intended to provide monies to improve the residency educational experience with the anticipated outcome being an increase in physicians choosing to practice primary care. It must be reiterated that this is primarily an educational program, not one intended to provide service to any specific population.

Primary care pediatric residency education is designed to produce primary care physicians capable of providing primary health care for infants, children and adolescents. Pediatricians are expected to manage both acute and chronic health problems, to care for children with emotional disturbances and disabling conditions, to provide counseling for problems that are psychosocial or behavioral in nature, to be aware of cultural and community influences, to utilize community resources, and to collaborate with other health care givers. We now know that many complex pediatric problems often can be best managed on an ambulatory or outpatient basis.

This means that the educational experience must be structured to provide appropriate training. The training often uses a variety of traditional and non-traditional sites and settings. These sites include community hospitals and tertiary care institutions, hospital-based ambulatory care clinics, community health centers, and private practitioners offices.

Unfortunately, such primary care training is expensive. Current payment sources, whether from direct payment by the patient or through third-party reimbursement, cannot cover the costs of using these non-traditional training sites. Inpatient, tertiary, and procedure oriented care are more lucrative sources of revenue for hospitals and training institutions; hospital-based ambulatory care and out-of-hospital sites, especially ones whose patients are low-income or Medicaid-eligible, do not generate the same level of income. However, the value of such training has been recognized -- most recently by the HHS Council on Graduate Medical Education in its July, 1988, report. The grants from the Title VII program can mean the difference between using inpatient and hospital-based training sites or those focused on providing primary health care.

While there have been few studies, it appears that a majority of the residents involved in the primary care training programs have gone on to practice primary care pediatrics or general internal medicine, with about 50 percent of them serving in rural or socioeconomically deprived urban areas. Such a record proves that it is possible to train primary care physicians who will serve the neediest populations.

For pediatrics overall, we do know that many (nearly thirty percent) residents continue training through at least one year of a subspecialty fellowship. Some of these individuals do not become board certified in that subspecialty and go into general pediatrics. Some subspecialties for pediatrics do not yet have a certifying exam. Many of the subspecialties for pediatrics enhance the ability to provide primary care -- i.e., adolescent medicine and behavioral pediatrics. It is our belief, however, that only a few residents completing a primary care training program continue training by entering a subspecialty fellowship.

CURRENT PROPOSALS

Our organizations advocate maintaining the existing program with the additional authority to use monies from this program for predoctoral grants to enhance medical students exposure to general pediatrics. Such clerkships are allowed in the family medicine program of Title VII and are an important source of funding for clerkships.

Funding for the program has fluctuated slightly over the past ten years, but, in essence, it has been decreasing. This has meant that some excellent programs are being approved but not funded. Also, the number of funded grants includes those receiving phase-down monies.

Our organizations are very concerned about the lack of access to health care, both due to financial and non-financial barriers. The Academy's top priority is to address this need. The Ambulatory Pediatric Association is developing guidelines for curriculum for programs to use in serving the underserved. We do not support legislating requirements that each grantee must document that its population base comes from a particular demographic strata or geographic area. Many of these programs currently provide care for the underserved populations, but that is done to fulfill an educational objective, not a service objective.

We also do not support H.R. 2231 which would amend this program to require medical schools and hospitals receiving a general internal medicine or general pediatrics grant to have, at a minimum, a tie to a medical school with a department or division of family medicine. Medical school curricula can be structured to give adequate experience and exposure to primary care without requiring a separate department or division of family medicine.

SUMMARY

In summary, the three organizations submitting this statement make the following recommendations:

- The Primary Care Training Grants for General Internal Medicine and General Pediatrics should be reauthorized.
- There should be additional authority included to allow for predoctoral clerkships for medical students to provide an educational experience in general pediatrics.
- There should not be specific requirements for providing service to underserved populations, rural or urban.
- There should not be a requirement that medical schools receiving these grants have a department or division of family medicine.

Over the span of this reauthorization we ask for the following authorization levels: fiscal year 1992 -- $27 million; fiscal year 1993 -- $31 million; fiscal year 1994 -- $36 million. The predoctoral grants should be new monies, not decrease the existing program.

Thank you for the opportunity to present our comments.

American Academy of Physician Assistants
950 North Washington Street, Alexandria, Virginia 22314

MR. CHAIRMAN, ON BEHALF OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS AND THE 22,000 PHYSICIAN ASSISTANTS (PAs) WE REPRESENT, I WANT TO THANK YOU FOR THIS OPPORTUNITY TO EXPRESS OUR VIEWS ON REAUTHORIZATION OF THE TITLE VII PROGRAMS OF THE PUBLIC HEALTH SERVICE.

FOR NEARLY 20 YEARS, THE FEDERAL GOVERNMENT HAS HELPED TO NURTURE AND FOSTER GROWTH IN THE PA PROFESSION. THE HEALTH AND ENVIRONMENT SUBCOMMITTEE UNDER YOUR LEADERSHIP HAS BEEN AN IMPORTANT PART OF THAT PROCESS.

IT IS IMPORTANT FOR MEMBERS OF THE SUBCOMMITTEE TO UNDERSTAND THAT THE FEDERAL GOVERNMENT'S SUPPORT FOR PA EDUCATION HAS HAD A TANGIBLE AND LASTING IMPACT ON ACCESS TO AFFORDABLE HEALTH CARE FOR MILLIONS OF AMERICANS - HEALTH CARE THAT BY AND LARGE WOULD NOT HAVE BEEN AVAILABLE WERE IT NOT FOR PHYSICIAN ASSISTANTS.

IT IS ALSO IMPORTANT TO NOTE THAT PAs, MORE THAN ANY OTHER HEALTH PROFESSION, HAVE MAINTAINED THEIR COMMITMENT TO SERVING THE MEDICALLY UNDERSERVED. ALTHOUGH THERE HAVE BEEN PERIODIC DIPS IN THE NUMBERS OF PAs WORKING IN UNDERSERVED COMMUNITIES, THE FACT REMAINS THAT MORE PAs, AS A PERCENTAGE OF THE PROFESSION, PRACTICE IN RURAL UNDERSERVED COMMUNITIES THAN IS TRUE OF ANY OTHER HEALTH PROFESSIONAL GROUP.

WHEN A DROP IN THE NUMBER OF PAs IN UNDERSERVED AREAS HAS OCCURRED, IT CAN OFTEN BE TRACED TO POLICY CHANGES ON THE PART OF GOVERNMENT RATHER THAN A CHANGE IN THE EDUCATION OR COMMITMENT OF PAs.

FOR EXAMPLE, IN THE EARLY 1980s, THE NATIONAL HEALTH SERVICE CORPS (NHSC) STOPPED ACCEPTING APPLICATIONS FROM PHYSICIAN ASSISTANTS AND DISCONTINUED RECRUITMENT OF PAs INTO THE CORPS. AS MIGHT BE EXPECTED, THIS LED TO A RATHER PRECIPITOUS DROP IN THE NUMBER OF PAs IN THE NATIONAL HEALTH SERVICE CORPS.

RECENTLY, THIS POLICY WAS DISCONTINUED THROUGH THE AVAILABILITY OF NHSC CORPS SCHOLARSHIPS FOR PA STUDENTS AND A SERIOUS EFFORT BY THE PUBLIC HEALTH SERVICE TO RECRUIT PA STUDENTS INTO THE CORPS. THE ENERGY & COMMERCE HEALTH SUBCOMMITTEE'S SUPPORT OF THE MID-LEVEL PRACTITIONER SCHOLARSHIP SET-ASIDE INCLUDED IN THE NHSC REVITALIZATION ACT LAST YEAR WAS CONSISTENT WITH THE CHANGE IN RECRUITMENT POLICY.

ALSO IMPORTANT TO THE SUCCESS OF THIS STRATEGY WAS THE 1988 DECISION BY THE PUBLIC HEALTH SERVICE (PHS) TO BEGIN COMMISSIONING PAs IN THE PHS. ONCE THAT OCCURRED, PA STUDENTS BECAME ELIGIBLE TO PARTICIPATE IN THE COSTEP OR COMMISSIONED OFFICER STUDENT EXTERN PROGRAM. THIS HAS PROVED TO BE A VALUABLE RECRUITMENT TOOL FOR PA STUDENTS OVER THE PAST TWO YEARS. MORE THAN 50 PA STUDENTS ARE PRESENTLY PARTICIPATING IN THE SENIOR COSTEP PROGRAM AND WILL BE ENTERING THE PUBLIC HEALTH SERVICE WHEN THEY GRADUATE.

THESE PROGRAMS HAVE BEEN SO SUCCESSFUL, MR. CHAIRMAN, THAT WE ANTICIPATE THAT CLOSE TO 10% OF THE 1992 PA CLASS WILL BE ENTERING THE PUBLIC HEALTH SERVICE UPON GRADUATION.

IT HAS BEEN SAID THAT THERE ARE NO TRULY NEW IDEAS, ONLY REPACKAGED OLD ONES. DESPITE MORE THAN 20 YEARS OF PROVIDING COST-EFFECTIVE, HIGH QUALITY HEATH CARE, SOME HEALTH ANALYSTS ARE ONLY NOW "DISCOVERING" THE PA PROFESSION. INDEED, IT HAS BEEN SUGGESTED THAT THE PA PROFESSION IS EXPERIENCING A RENAISSANCE.

BUT THE REDISCOVERY OF THE PA PROFESSION BY BOTH THE PRIVATE SECTOR AND THE PUBLIC HEALTH COMMUNITY HAS NOT COME WITHOUT PROBLEMS. ACCORDING TO THE LATEST SURVEY OF PA PROGRAMS, THERE ARE AN ESTIMATED 7 JOBS FOR EVERY STUDENT GRADUATING IN 1991. THIS HAS SERIOUS IMPLICATIONS FOR THE PUBLIC HEALTH COMMUNITY IN GENERAL, AN THE PA PROFESSION IN PARTICULAR.

THE ACADEMY AND THE PROFESSION HAVE STRUGGLED WITH THE INCREASE IN DEMAND FOR PHYSICIAN ASSISTANTS. QUITE FRANKLY, THE PROFESSION WAS OVERWHELMED BY MARKET FORCES THAT SURFACED IN THE PAST FEW YEARS.

I AM PLEASED TO REPORT, HOWEVER, THAT WE BELIEVE WE HAVE PURSUED A STRATEGY THAT WILL BOTH HELP TO MEET THE MARKETPLACE DEMAND FOR PAs AND ASSURE A CONTINUED SUPPLY OF PAs FOR UNDERSERVED AREAS.

CENTRAL TO THE SUCCESS OF OUR STRATEGY WAS INCREASING THE APPLICANT POOL. EARLY IN THE PLANNING PROCESS, WE DECIDED THAT WE DID NOT WANT TO SIMPLY TRY TO INCREASE CLASS SIZE WITHOUT FIRST ASSURING THAT THERE WERE QUALIFIED APPLICANTS TO FILL THESE NEW SLOTS. THROUGH THE COMBINED PUBLIC EDUCATION EFFORTS OF THE ACADEMY AND THE ASSOCIATION OF PA PROGRAMS, WE WERE ABLE TO HAVE A POSITIVE EFFECT ON THE APPLICANT POOL. MORE IMPORTANTLY, THROUGH AN INNOVATIVE PROGRAM CALLED PROJECT ACCESS, WE HAVE INCREASED AWARENESS OF THE PA PROFESSION IN THE MINORITY COMMUNITY.

PROJECT ACCESS WAS STARTED BY THE ACADEMY FOUR YEARS AGO IN AN ATTEMPT TO INCREASE PUBLIC AWARENESS OF PHYSICIAN ASSISTANT CAREER OPPORTUNITIES FOR MINORITIES. HELD IN CONJUNCTION WITH THE AAPA'S ANNUAL MEETING, TEAMS OF PAs, PA STUDENTS AND FACULTY VISIT PREDOMINANTLY MINORITY HIGH SCHOOLS AND JUNIOR COLLEGES IN THE HOST CITY OF OUR ANNUAL MEETING.

ON MAY 28TH, OVER 100 PARTICIPANTS VISITED MORE THAN 20 SCHOOLS IN SAN FRANCISCO AND THE SURROUNDING COMMUNITIES. THE PROJECT ACCESS TEAMS TOOK THE PA MESSAGE OF IMPROVED ACCESS TO QUALITY HEALTH CARE TO OVER 1,000 YOUNG PEOPLE IN THE BAY AREA.

THIS PROJECT IS FUNDED ENTIRELY BY THE ACADEMY AND RELIES HEAVILY ON THE TIME AND EFFORT OF TEAMS OF VOLUNTEERS. WE ARE PROUD OF THE SUCCESS OF PROJECT ACCESS AND CHALLENGE OTHER HEALTH PROFESSIONAL ORGANIZATIONS TO UNDERTAKE A SIMLIAR PROGRAM.

THE SUCCESS OF THIS STRATEGY CAN BE SEEN IN THE MOST RECENT STATISTICS WHICH SHOW THAT WE NOT ONLY INCREASED THE NUMBER OF MINORITIES ENTERING THE PA PROFESSION, BUT WE HAVE ALSO ARRESTED THE DECLINE IN THE NUMBER OF PAs IDENTIFYING RURAL OR UNDERSERVED AREAS AS THEIR AREA OF PRACTICE. IN FACT, MR. CHAIRMAN, IN 1991 WE SAW AN INCREASE IN THE NUMBER OF RURAL PAs. ACCORDING TO THE LATEST STATISTICS, OVER 15% OF PAs IDENTIFY RURAL COMMUNITIES WITH POPULATIONS OF UNDER 10,000 AS THEIR SITE OF PRACTICE. THIS IS UP FROM JUST UNDER 13% ONE YEAR AGO.

BUT WHILE THE PROFESSION IS TAKING A PRO-ACTIVE STANCE ON ADDRESSING UNMET HEALTH CARE NEEDS, WE WILL NEED THE SUPPORT OF THE FEDERAL GOVERNMENT IF OUR POLICIES ARE TO HAVE ANY LONG-TERM SUCCESS.

CRITICAL TO OUR LONG TERM STRATEGY OF INCREASING THE NUMBER OF PAs WORKING IN UNDERSERVED URBAN AND RURAL AREAS IS INCREASING THE NUMBER OF PAs GRADUATING EACH YEAR. THIS CAN BE ACCOMPLISHED THROUGH TWO MEANS - INCREASING THE NUMBER OF PA PROGRAMS AND INCREASING CLASS SIZES AT EXISTING PA PROGRAMS.

SUCCESS AT IMPROVING THE APPLICANT POOL FOR PA PROGRAMS HAS IN TURN ALLOWED PROGRAMS TO INCREASE CLASS SIZES. PRELIMINARY DATA INDICATE THAT THE 1991 ENTERING CLASS WAS 500 STUDENTS LARGER THAN THE HISTORICAL ENTERING CLASS SIZE OF 1200 STUDENTS.
BUT WE HAVE JUST ABOUT WRUNG EVERY OUNCE OF EXTRA SPACE OUT OF THE EXISTING NETWORK. TO MAKE ANY ADDITIONAL APPRECIABLE

GROWTH, WE MUST ADD NEW PA PROGRAMS. UNFORTUNATELY, THIS IS AN EXPENSIVE UNDERTAKING. INTERESTINGLY ENOUGH, THERE ARE UNIVERSITIES IN SEVEN STATES THAT ARE IN VARIOUS STAGES OF PLANNING THE ESTABLISHMENT OF PA PROGRAMS. IN ADDITION TO THOSE INSTITUTIONS IN THE PLANNING PHASE, PA PROGRAMS AT DUQUESNE UNIVERSITY AND THE CHICAGO COLLEGE OF OSTEOPATHIC MEDICINE HAVE RECENTLY BEGUN THE FORMAL ACCREDITATION PROCESS.

BOTH THE DUQUESNE AND CHICAGO PROGRAMS WILL BE ASSISTED BY GRANTS FROM THE FEDERAL GOVERNMENT. WHILE SEVERAL OF THE UNIVERSITIES PLANNING PA PROGRAMS ARE COMMITTED TO THE PROCESS REGARDLESS OF THE AVAILABILITY OF FFEDERAL FUNDS, THE SPEED WITH WHICH THEY MOVE THROUGH THE PROCESS WILL BE AFFECTED BY THE AVAILABILITY OF FEDERAL FUNDS.

VERY LITTLE FEDERAL GRANT MONEY IS AVAILABLE FOR NEW STARTS BECAUSE MUCH OF THE MONEY IS ALREADY COMMITTED TO EXISTING PA PROGRAMS - MONEY, BY THE WAY, WHICH IS RESPONSIBLE FOR THE CURRENT HIGH PERCENTAGE OF PAs WORKING IN UNDERSERVED AREAS.

TO SHIFT MONEY WITHIN THE EXISTING AUTHORIZATION/APPROPRIATIONS LIMITS WOULD SIMPLY RESULT IN ROBBING PETER TO PAY PAUL. WHAT WE NEED, MR. CHAIRMAN, IS AN INCREASE IN THE AUTHORIZATION LEVEL FOR PA EDUCATION GRANTS, AS WELL AS THE APPROPRIATIONS LEVEL.

INDICATIONS FROM SOME APPROPRIATIONS COMMITTEE MEMBERS ARE THAT THEY WOULD SUPPORT AN INCREASED APPROPRIATION IF WE COULD RAISE THE AUTHORIZATION CEILING. WE MAKE THAT REQUEST TODAY.

WE ASK THAT THE AUTHORIZATION LEVEL FOR PA EDUCATION GRANTS BE RAISED FROM THE CURRENT CEILING OF $5.4 MILLION TO $8.0 MILLION IN FY 1992, $8.5 MILLION IN FY 1993 AND $9.0 MILLION IN FY 1994. BASED UPON HISTORICAL SPENDING FIGURES, MR. CHAIRMAN, THIS DOES NOT ACTUALLY REPRESENT AN INCREASE, BUT RATHER A RETURN TO THE FUNDING LEVEL THAT EXISTED IN THE EARLY 1980s.

WE REQUEST THIS AMOUNT BECAUSE WE BELIEVE IT WILL PROVIDE SUFFICIENT FUNDS TO SUPPORT THE CREATION OF NEW PA PROGRAMS, AND WILL CONTINUE TO PROVIDE ADEQUATE SUPPORT TO EXISTING PA PROGRAMS. IN THIS WAY, CURRENT GRANT RECIPIENTS CAN CONTINUE THEIR MISSION OF PROVIDING WELL TRAINED PHYSICIAN ASSISTANTS WHO WILL PRACTICE IN UNDERSERVED URBAN AND RURAL AREAS.

WE ALSO REQUEST, MR. CHAIRMAN, THAT THE AUTHORIZATION LANGUAGE BE CHANGED SO THAT GRANT FUNDS CAN BE USED FOR FACULTY DEVELOPMENT.

ONE OF THE MAJOR IMPEDIMENTS TO INCREASING THE NUMBER OF GRADUATES IS HAVING APPROPRIATE FACULTY TO EDUCATE THESE FUTURE PAs. BY PERMITTING THE GRANT MONEY TO BE USED FOR FACULTY DEVELOPMENT, AN ADEQUATE SUPPLY OF PA EDUCATORS FOR BOTH THE NEW AND EXISTING PA PROGRAMS CAN BE ASSURED.

THE PA PROFESSION HAS A PROUD TRADITION OF PROVIDING HIGH QUALITY COST-EFFECTIVE HEALTH CARE IN AREAS SHUNNED BY OTHER HEALTH CARE PROVIDERS. THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS AND THE ASSOCIATION OF PHYSICIAN ASSISTANT PROGRAMS REMAIN COMMITTED TO ADDRESSING SOCIETAL GOALS OF ACCESS TO HEALTH CARE FOR ALL AMERICANS. WITH THE CONTINUED SUPPORT AND ENCOURAGEMENT OF THE FEDERAL GOVERNMENT, WE CAN CONTINUE TO MEET THAT MISSION.

MR. CHAIRMAN, ATTACHED IS A BRIEF FACT SHEET WHICH COMPARES FEDERAL SUPPORT FOR PA EDUCATION IN 1983 WITH FEDERAL SUPPORT FOR PA EDUCATION IN 1991. AS YOU CAN SEE, PA PROGRAMS ARE DOING MORE WITH LESS FEDERAL SUPPORT BUT WE ARE STRETCHED TO THE LIMIT. WE TRUST WE CAN CONTINUE TO COUNT ON YOUR SUPPORT.

FEDERAL SUPPORT FOR PA EDUCATION

Background:

In 1984, the average federal grant to a PA program was $131,000 and that grant represented 47% of the PA program's budget. It is not an exaggeration to say that in 1984 PA programs were heavily dependent upon federal support for their financial existence. In 1990, the average federal grant to a PA program was $128,000, a slight decline from 1984. The good news is that in 1990, federal grants represented only 31% of the average PA program's budget.

We believe it is even more interesting to note that a typical PA program in 1984 had an average class size of 24 students. Contrast that with today's average class size of 30 students. The federal government is supporting more PA students in 1990 at lower cost to the taxpayer than it was supporting in 1984.

We believe the time has come for a significant increase in federal support for PA education.

Federal Support for PA Education - 1984 & 1990

	1984	1990
Average Fed Grant	$131,000	$128,000
Ave PA Prog Budget	$277,000	$410,000
Average Class Size	24.5	29.8

AARC
AMERICAN ASSOCIATION FOR RESPIRATORY CARE
11030 Abies Lane, Dallas, TX 75229, 214/243-2272, Fax 214/484-2720

Mr. Chairman and Members of the Sub-committee:

The American Association for Respiratory Care (AARC), a 30,000-member professional association of respiratory care practitioners, welcomes the opportunity to submit written testimony on the hearing to amend Title VII of the Public Health Service Act. The purpose of our testimony is to encourage the sub-committee to support provisions for allied health education and training initiatives.

Respiratory care is an allied health specialty functioning under medical direction that participates in the assessment, treatment, management, control, diagnostic evaluation, and care of patients with deficiencies and abnormalities of the cardiopulmonary system.

The patients, for whom respiratory care practitioners render service, range from the premature infant in a hospital intensive care unit to elderly patients suffering from such chronic lung diseases as emphysema and asthma. Respiratory care practitioners are also treating and caring for a growing number of AIDS patients. At some point during their illness, the majority of AIDS patients (80%) develop Pneumocystis carinii pneumonia (PCP), a serious pulmonary infection, often treated with aerosolized pentamidine administered by the respiratory care practitioner.

As medical technology continues to advance, the length and quality of chronic lung patients' lives can also be enhanced through the application of pulmonary rehabilitation. Respiratory care practitioners are specifically trained and educated to provide a range of respiratory services including both outpatient and home pulmonary rehabilitation.

However, as with our other allied health colleagues, the respiratory care community is facing a serious shortage of qualified personnel, i.e. registered respiratory therapists and certified respiratory therapy technicians. According to the most recent American Hospital Association survey, hospitals suffer from an 8.9% vacancy rate for respiratory care practitioners. The Bureau of Labor Statistics predicts that by the year 2000, the demand for respiratory care practitioners will increase by 34%. A 1990 Health and Human Services report states the following: "As the number of elderly increases, the demand for allied health practitioners in a variety of fields will rise accordingly, and combined with greater longevity, will have a significant impact on demand for practitioners in rehabilitation fields such as occupational therapy, physical therapy, respiratory therapy, and audiology."

To help address these growing critical shortages, Congressman Terry Bruce has taken to the forefront and introduced HR1466 which would provide the necessary funding for allied health training and education. The AARC strongly commends the support Congressman Bruce has shown for the allied health community. We urge the sub-committee members to seriously review the provisions of HR1466.

Respiratory care plays a significant role in the rehabilitation of the elderly and disabled. As the population continues to age, greater numbers of respiratory care practitioners will be needed to meet the health care requirements of these pulmonary patients. Legislation such as HR1466 will significantly improve the likelihood that this growing demand for quality respiratory care services will be satisfied.

STATEMENT OF THE
AMERICAN COLLEGE OF PREVENTIVE MEDICINE

The American College of Preventive Medicine is the national medical specialty society of physicians whose primary interest and expertise is preventive medicine and public health. Our members work in public health agencies, in clinical medicine, in industry, and in academia. Many are board-certified in the specialty of preventive medicine. The College membership constitutes a major national resource of expertise in disease prevention and health promotion, areas vital to protecting and improving the nation's health.

The American College of Preventive Medicine urges reauthorization and modestly higher levels of authorized funding for those programs under Title VII of the Public Health Service Act that train physicians and other professionals in preventive medicine and public health.

TRAINING IN PREVENTIVE MEDICINE

Our nation's leaders in health have committed the country to achieving specific objectives in health promotion and disease prevention by the year 2000. However, we cannot do this without a cadre of well-trained professionals in our nation's health agencies, community-based organizations, private and non-profit institutions and industry. The institutions that produce these leaders are suffering, and cannot meet the needs for the public health workforce without more support.

Preventive Medicine is a medical specialty recognized by the American Board of Medical Specialties. It encompasses general preventive medicine, public health, occupational medicine, and aerospace medicine. Physicians trained in preventive medicine are the leaders in local and state efforts to preserve and promote good health. Working with large population groups, as well as with individual patients, they seek to understand the risks of disease, disability and death and to reduce or eliminate these risks.

There is a well-documented national shortage of physicians specializing in preventive medicine. Such a shortage was projected in 1980 by the the Graduate Medical Education National Advisory Committee (GMENAC). Since then, the HHS Council on Graduate Medical Education (COGME) and the HHS Secretary's reports on the status of U.S. health personnel have consistently reaffirmed this shortage.

Many preventive medicine specialists receive their postgraduate training in preventive medicine residency programs. Nationally, there are 78 accredited residency programs. In 1989-90, a total of 513 physicians were being trained in these programs. This means that each year an average of about 170 such specialists complete their training.

This fiscal year, federal funds totalling $1.6 million were appropriated to support postgraduate training in preventive medicine. This sum has remained essentially unchanged for the last five years. In fiscal year 1991, these funds provided stipends for 53 residents in 11 programs. There are 67 other accredited residency training programs in the country that received no funding. For every slot available in these programs, there have been approximately four qualified applicants.

Why do we need federal subsidies for this training? Postgraduate education in preventive medicine is unlike that for any other medical specialty. Only the first year of training is in hospital-based clinical medicine, which is funded in the same way as any other first-year residency, through third-party reimbursement for services. However, the second year consists of academic work leading to a masters degree in public health or an equivalent degree. The third year is a practicum. The resident may participate in a broad range of clinical, research, and administrative activities, almost always in settings for which these activities are non-reimbursable. After their residency training, many of these physicians go on to practice in the public sector, where levels of compensation are appreciably lower than those available in other medical specialties.

Currently, residency programs scramble to put together funding packages for their residents. As the state, local and private funds used for this purpose have grown more and more scarce, the value of the meager federal funding in real dollars has decreased. Accordingly, we urge a renewed commitment to training in preventive medicine through reauthorization of grants for preventive medicine residencies with an authorized appropriation of $5 million for fiscal year 1991, an increase of $1 million over this year's $4 million authorization. For fiscal years 1993 and

1994 we propose authorized levels of $7 million and $10 million, respectively. These are modest sums indeed for such a crucial investment in the future of public health.

TRAINING IN PUBLIC HEALTH

The training of public health professionals is closely linked to preventive medicine. The nation's 24 schools of public health provide training for physician specialists in preventive medicine as well as for many other health professionals who comprise our public health workforce. Secretary Sullivan reported in March 1990 that, in addition to the shortage of physicians trained in public health and preventive medicine, there are shortages of epidemiologists, biostatisticians, environmental and occupational health specialists, public health nutritionists, and public health nurses. In spite of these facts, the limited but vital federal support for public health training has been declining slowly since the early 1980s. We join with the schools of public health in requesting increased appropriations for three additional training programs under Title VII of the Public Health Service Act. For traineeships to support students that choose to enter careers in short supply, we suggest authorization of appropriations of $10, $15, and $20 million for the next three fiscal years. We ask equal amounts for special projects for curriculum development in areas that address the federal health objectives for the year 2000. The Health Careers Opportunity Program, which supports recruitment of underrepresented minorities into the health field, merits authorized levels of funding of $40, $42, and $45 million for fiscal years 1992 through 1994.

Our nation spends billions of dollars on acute health care. Compared to this, our investment in prevention continues to lag. The frightening increases in health care costs we have witnessed are not a reason to cut back on programs and funds dedicated to prevention. They are a reason to make a larger investment now. Training the professionals who provide leadership in prevention is a critical step in sustaining and strengthening the infrastructure that, given the resources, can keep Americans healthier.

STATEMENT OF
THE AMERICAN DENTAL HYGIENISTS' ASSOCIATION

The American Dental Hygienists' Association ("ADHA") appreciates this opportunity to present its views regarding reauthorization of Title VII of the Public Health Service Act. ADHA represents 30,000 members across the country dedicated to assuring the highest level of preventive oral health care. Originally formed to develop communication and mutual cooperation among hygienists, ADHA today serves as an advocate for dental hygienists at the federal, state and local levels.

Allied health professionals are playing an increasingly critical role in our nation's health care delivery system. Efforts to bring runaway health care costs under control will inevitably include enhanced utilization of high-quality, low-cost allied health services in substitution for more expensive institutional care. Thus, federal support for education in the allied health professions through Title VII is a wise investment in the future of quality health care in this country. Greater federal support in this area will help to draw more and better qualified persons into these professions. We strongly urge Congress to reject the Administration's proposal, contained in its FY 1992 budget recommendations, to repeal these programs.

Dental hygienists play a vital cost-effective role in the delivery of oral health care services parallel to that of registered nurses in the delivery of medical services. Dental hygienists perform numerous preventive and therapeutic services. Success in preventive oral health care -- largely due to the widespread use of fluorides -- has caused significant changes in patterns of delivery of oral health services. The decline in recent years of public demand for more traditional oral health services has resulted in dentists spending substantially less time performing restorative services. Indeed, oral health services have become much more prevention-oriented -- the traditional domain of dental hygiene.

While a great deal of progress has been made in improving the oral health of most Americans, a great deal remains to be done. For example, a 1987 survey conducted by the National Institute of Dental Research found that senior citizens had a 63 percent incidence of tooth caries. The dental hygiene profession is extremely interested in playing a greater role in the delivery of preventive oral health services to underserved populations such as the elderly, poor children, and the handicapped.

In pursuit of this objective, an area of particular interest to ADHA is the training of baccalaureate level dental hygiene students for public health settings. Title VII does not currently allow for advanced traineeships for these students, yet we have found a critical need within dental hygiene for additional support in this area. ADHA is currently undertaking a major effort to recruit public health dental hygienists into a variety of federal, state, and local oral health programs. Our research thus far indicates a strong need for support of students interested in these types of careers. Accordingly, ADHA urges this Committee to provide additional funding for advanced training of allied health personnel and to open this program to baccalaureate level students interested in public health careers.

ADHA also joins the American Society of Allied Health Professions in support of H.R. 1466, introduced by Congressman Terry Bruce, which would amend Title VII to increase support for allied health. This bill would set authorization levels of $7 million for advanced-level traineeships and $7 million for allied health grants and contracts for FY 1992. In addition, the legislation would enhance the visibility of allied health issues within the federal government through creation of a new Division of Allied Health within the Bureau of Health Professions and a corresponding advisory Commission on Allied Health.

The dental hygiene community stands ready to assist in efforts to enhance access to oral health services. Adequate funding of the Title VII education support programs is critical to these efforts.

We thank you again for this opportunity to present our views.

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STATEMENT OF THE AMERICAN ASSOCIATION OF BIOANALYSTS

The American Association of Bioanalysts (AAB), an organization representing the directors, owners, managers, and supervisors of independent community clinical laboratories across the United States, appreciates this opportunity to comment on legislative proposals related to reauthorization of Title VII of the Public Health Service Act.

Our testimony is directed toward the substantial shortage of clinical laboratory technologists. This shortage is nationwide but it is most acute in rural and inner-city areas. Community-based clinical laboratories, hospitals, and physicians' offices are having tremendous difficulty attracting qualified laboratory technologists.

This problem is likely to be further exacerbated by the new personnel rules which have been proposed to implement the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88). These rules require virtually every hospital and most physician offices to employ technologists who either hold a four-year degree in laboratory technology or can demonstrate that they have successfully passed the HHS Proficiency Exam.

AAB believes this serious problem should be addressed by incorporating the Rural Clinical Laboratory Personnel Shortage Act, H.R. 2405 into this year's reauthorization of Title VII. H.R. 2405 was introduced by Representative Jim Slattery (D-KS) and 42 other Members of the House on May 20. This bill is designed to reduce both the immediate and long-term shortage of laboratory technologists by:

1) Authorizing the Secretary of HHS to (a) establish a loan forgiveness program for laboratory technologists who agree to serve in rural and other underserved areas and (b) provide financial assistance to educational programs designed to increase the number of laboratory personnel serving in these areas;

2) Requiring the Secretary to administer a proficiency examination on an annual basis to provide an alternative entry route for individuals who do not have a baccalaureate degree in laboratory services; and

3) Establishing a procedure for shifting the credentialling of laboratory technologists to qualified private professional organizations.

We are particularly pleased that this measure includes reauthorization of an HHS proficiency exam. The HHS Exam allows military veterans, junior college graduates, and other individuals with significant work experience or educational training to qualify as laboratory technologists. For example, the military trains hundreds of technologists a year. Without the HHS Exam, the skills acquired by these soldiers, sailors, and airmen are not recognized in the civilian workforce.

The proficiency exam section of H.R. 2405 is virtually identical to a provision which the Energy and Commerce Committee adopted during the 1988 reauthorization of Title VII. This section is also supported by a wide variety of other organizations including:

American Hospital Association
American Medical Technologists
American Society for Medical Technology
House Rural Health Care Coalition
International Society for Clinical Laboratory Technology
National Vietnam Veterans Coalition
Fleet Reserve Association
Air Force Association
Non-Commissioned Officers Association
Naval Reserve Association

and the following 19 state hospital associations:

Arkansas Hospital Association
Colorado Hospital Association
Association of Delaware Hospitals
Iowa Hospital Association
Illinois Hospital Association
Indiana Hospital Association
Kansas Hospital Association
Louisiana Hospital Association
Massachusetts Hospital Association
Minnesota Hospital Association
Missouri Hospital Association
Montana Hospital Association
Nebraska Hospital Association
Nevada Hospital Association
North Carolina Hospital Association
Oregon Hospital Association
South Dakota Hospital Association
Texas Hospital Association
Washington State Hospital Association.

B. Shortage of Laboratory Technologists

The shortage of qualified laboratory technologists is straining community-based clinical laboratories and hospitals across the country. The shortage is well-documented. Even the American Society for Clinical Pathology (ASCP), which claimed that there was an adequate supply of medical technologists in 1988, now acknowledges an "alarming" shortage of these personnel. ASCP completed an extensive survey of this problem in 1990 and reported that vacant positions of staff medical technologists had doubled since 1988. According to the ASCP study, 71% of all laboratory managers surveyed reported having trouble filling medical technologist openings. A similar study by the American Society for Medical Technology (ASMT) in 1989 found clear evidence of the "development of a significant workforce crisis within the clinical laboratory sciences." Over 41% of laboratory managers surveyed by ASCP indicated that it took greater than eight weeks to fill vacancies, and 25% of the laboratories reported being understaffed.

The current shortage is likely to be compounded manyfold when CLIA '88 is implemented. The federal government, state agencies, and private accrediting bodies are expected to hire a substantial number of laboratory technologists to implement the enforcement and accreditation sections of CLIA '88. More importantly, the May 20, 1990 proposed rule requires for the first time that individuals working in hospitals and physician offices must have at least a baccalaureate degree or have passed the HHS Examination in order to qualify as a technologist.

C. Alternative Solutions

Some have suggested that the personnel shortage should be dealt with by "grandfathering" all existing employees. This approach is irresponsible and inconsistent with the Committee's efforts to improve the quality of laboratory services. Grandfathering would permit any secretary, technician, or technologist who has ever performed a laboratory test to continue to do so regardless of their training, experience or competency.

In fact, this approach may even diminish the current standard for the most regulated sector of laboratory testing -- independent laboratories. These laboratories currently must hire individuals who have passed the HHS Exam or have a four-year degree. If all employees currently performing tests were grandfathered, independent laboratories will be able to hire anyone regardless of experience or training as long as that person has conducted laboratory tests in either a hospital or a physician's office.

Others have suggested that the best way to deal with the shortage of laboratory personnel is to provide funding for schools which train medical technologists. However, to be effective federal funding must be targeted to encouraging students to become laboratory technologists and providing incentives for these students to practice in rural or underserved areas. Medical technology programs are finding it extremely difficult to attract students. For example, between 1982 and 1988, enrollment in four-year baccalaureate degree programs declined 35%. Low wages, lack of opportunities for advancement, and fear of the AIDS epidemic are believed to contribute to the decline in the number of new students. The primary focus of federal funds should be placed on attracting students.

Moreover, even if these programs were adequately funded and were able to attract and retain additional laboratory personnel, this approach does not provide any immediate relief. At best, it will take four to five years before the graduates of these programs enter the workforce.

D. The HHS Proficiency Examination

AAB advocates the development and administration of a revised and updated HHS Proficiency Exam. This exam would be administered by the Department until the shortage of laboratory personnel abates.

There are thousands of individuals who are currently working in hospital laboratories and physicians' offices who have significant experience and training in laboratory sciences. In the past, they could take the HHS Exam to demonstrate their competency. If they passed, they would be qualified to hold laboratory technologist positions in independent laboratories. However, since the exam is no longer given, there is no way for these individuals to enter the profession regardless of their experience and ability.

The Department administered the HHS Exam seven times between 1974 and 1987 to 65,000 individuals. Approximately 46% passed. In order to sit for the exam, applicants had to meet certain minimum experience and/or educational qualifications. In general, an applicant was required to have a combined total of four years' experience or training in the clinical laboratory field after graduating from high school.

The HHS Proficiency Exam was developed by the Professional Examination Service (PES) with the input and cooperation of all of the professional organizations involved in clinical laboratory testing. PES is one of the three leading testing firms in the country and has developed several state examinations. The exam developed by PES was criterion-referenced, and an extensive validation study was performed. In fact, this is one of the few examinations in the credentialling field on which a predictive validity study has been performed. The predictive validity coefficients obtained through this study were high compared with most such coefficients obtained on similar examinations.

Based on the belief in Congress that there was an adequate supply of laboratory technologists, the authority to conduct additional exams was repealed in 1988. At the time, some of the professional groups argued that they could supply an adequate number of four-year graduates to meet future health care needs. It was also argued that anyone who wanted to take the test had an opportunity to do so between 1974 and 1988. Neither argument is valid today. The four-year programs have simply not been able to attract enough students to meet the demand for laboratory personnel, and there are thousands of individuals working in hospitals or physicians' offices who did not take the HHS Exam when it was given because at the time it was not a requirement to retain their jobs. In fact, some of the organizations which felt the exam was no longer necessary in 1988 are now supporting reauthorization.

When the authority for the exam was deleted in 1988, the House and Senate Conferees noted that:

> . . . there may develop a shortage of such personnel in the future. If this occurs, the conferees anticipate that consideration could be given to the appropriateness of authorizing a new examination for such personnel. House Conference Report No. 100-661; May 31, 1988.

Later that same year, the House Energy and Commerce Committee agreed to reinstate the exam as part of the 1988 reauthorization of the Health Professions Act. Unfortunately, this provision did not survive in conference.

It is essential that a new examination be developed in cooperation with all the relevant private professional certifying agencies. There are four professional organizations which certify laboratory technologists: the International Society for Clinical Laboratory Technology (ISCLT), the National Certifying Agency for Medical Laboratory Personnel (ASMT's certifying agency), the American Medical Technologists (AMT), and the American Society of Clinical Pathology (ASCP). Each of these organizations has substantial expertise in the development of testing procedures for laboratory personnel and each uses a written test as a key element of their own certification process. We have little doubt that these groups working with HHS can develop a high-quality examination.

E. Conclusion

We urge the Committee to incorporate H.R. 2405 into the 1991 reauthorization of the Health Professions Act. This bill provides a comprehensive response to the short- and long-range shortage of laboratory personnel, it is consistent with previous Committee action, and it will help avert a crisis when the CLIA '88 regulations are finalized.

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Statement of the
American Hospital Association
and the American Organization of Nurse Executives
for the record of the
Subcommittee on Health and the Environment
of the
Committee on Energy and Commerce
on
The Reauthorization of Title VII and VIII of the
Public Health Service Act

June 13, 1991

The American Hospital Association (AHA), on behalf of its nearly 5,500 member institutions, and the American Organization of Nurse Executives (AONE), representing over 5,300 nurse executives and nurse managers from health care institutions across the United States, welcomes this opportunity to provide a statement for the record of the Subcommittee on Health and the Environment of the House of Representatives' Committee on Energy and Commerce regarding the reauthorization of Titles VII and VIII of the Public Health Service Act. As the single largest sector of the health care system employing health professionals, hospitals are deeply committed to the development of public and private programs that will assure the availability of the number and types of health care professionals needed to assure adequate access to health care services for everyone.

Hospitals today face serious shortages of health care personnel in the allied health professions and nursing. Despite their best efforts to recruit qualified individuals and to retain those professionals they now have, there remain critical disparities between the demand and the supply of professionals needed to provide for the growing numbers of elderly, disabled, and chronically ill. In the past, recognizing the danger to the public health of personnel shortages, and the inability of the market for health manpower to operate efficiently, the federal government has played a significant role in supporting individuals and programs to assure an adequate supply of qualified personnel. The AHA supports the reauthorization and adequate funding of Titles VII and VIII of the Public Health Service Act. We believe the federal government must continue to play a strong role in the support of training allied health and nursing personnel.

The AHA has spent the last year evaluating the many problems currently plaguing our health care system. Our efforts at this point take the form of a proposal called *National Health Care Strategy: A Starting Point for Debate* which we hope will stimulate discussion about national health care reform.

In order to achieve reform of health care delivery and financing, AHA believes we need to develop a more coherent and comprehensive approach to meeting health manpower needs. Public policy decisions at the national, state, and local levels and local program decisions should all work toward the central goals of adequate supply, efficient use, and appropriate geographic distribution of qualified health care professionals. Actions designed to deal with these issues must be based on sound assessments of manpower needs and should address both short- and long-term goals.

Our strategy contains a series of recommendations designed to achieve these goals by providing for:

- regular and comprehensive national assessments of future health manpower needs;
- incentives to attract qualified students to the health professions;
- the stabilization of existing training programs, promotion of new programs where needed, and reorientation of training programs to future needs;
- greater career mobility within health care professions;
- To the elimination of barriers (particularly regulatory barriers) to the efficient use of health care professionals; and
- incentives to attract and retain health care professionals in poor, remote, or underserved areas.

A copy of our national health reform strategy is appended to this testimony for the Committee's review. In this statement, we would like to discuss several issues related to Title VII and Title VIII, and speak to specific allied health and nursing shortage problems faced by hospitals.

Title VII
Allied Health Professionals

The Need for Innovative Approaches to Increasing Allied Health Manpower

In the past decade, the demand for qualified health care personnel has increased substantially, surpassing the capacity of existing training programs for several occupational categories. The 1989 AHA Survey of Human Resources showed high vacancy rates for physical therapists (16.4 percent), occupational therapists (13.6 percent), speech pathologists (9.9 percent), and respiratory therapists (8.9 percent). Persistent high vacancy rates exist for occupational therapy assistants, physical therapy assistants, certified registered nurse anesthetists and clinical perfusionists.

These shortages are likely to continue through the next decade. The Bureau of Labor Statistics predicts significant continued growth in the demand for health professionals by the year 2000. Even using moderate assumptions of economic growth during the period, the BLS predicts increases by 50 to 60 percent in the demand for occupational and physical therapists. Despite increasing student interest in application for admission to PT programs, the present number of programs limits the ability of the educational system to meet the growth in demand for physical therapists.

At the same time, the Committee on Allied Health Education and Accreditation, which accredits educational programs in 26 allied health categories, shows a decline in programs, enrolled students, and graduates since 1984 in several categories. To cite only two examples, the number of Medical Technology programs dropped from 615 to 436, and the number of radiography programs from 760 to 666. The 1988 study of the role of allied health personnel in health care delivery by the Institute of Medicine (IOM) similarly found that many allied health fields face substantial loss of applicants and closure of training programs, which has caused significant supply problems. The IOM cited demographic and market factors as contributing causes.

The 1990 Department of Health and Human Services *Seventh Report to the President and Congress on the Status of Health Personnel in the United States*, reflecting on the growing shortages in critical professional categories, identified some of the problems that need to be addressed to resolve our manpower problems, including "reductions in program enrollments, closures of training programs, underrepresentation of minorities, and shortages in faculty and trained researchers." In addition to enrollment declines and program closures, training programs face a high student attrition rate. The 1988 CAHEA survey showed dropout rates in programs for respiratory therapy, medical laboratory technology, and surgical technology ranging from one-fifth to one-third of enrolled students.

Solving the problems of health manpower shortages will require more than subsidizing students and programs. Federal funding for allied professions should be used to stimulate innovative approaches to the resolution of the many problems behind the manpower shortages.

For example, to increase the number of individuals entering the health professions, federal funds could be used to develop programs to recruit individuals for professional training, perhaps through career exploration or career awareness programs to raise the level of awareness of the opportunities in the health professions among students emerging from high schools. In addition, given the expected demographic decline in the number of "traditional" students, funds could be targeted to "non-traditional" students -- older individuals returning to school or reentering the job market, or individuals already in the workforce who want to change careers, or minorities and disadvantaged groups like the disabled now lacking in schooling opportunitites. In addition, to combat the student attrition problem, funds could support student retention programs, e.g., support for transportation or child care. New methods of competency assessment and innovative articulation programs could be supported to increase the recognition of experience and past educational accomplishments in nursing and the allied health professions.

To enhance the efficiency of health manpower utilization, federal programs could support interdisciplinary training programs to maximize training resources, combining a core science curriculum with multi-task training for multicompetent personnel. This would have particular impact on rural areas, where nurses and other allied health professionals in hospitals are frequently required to perform several functions because of personnel shortages.

To overcome maldistribution of personnel, federal support for students could be combined with special inducements to serve in rural areas and support for training programs could be used to stimulate the development of clinical training programs for students as well as workers in rural areas who may wish to enhance their training or articulate to higher levels of performance.

In reauthorizing Title VII, we urge you to consider flexible and innovative funding to stimulate new approaches to the resolution of personnel shortages.

The Allied Health Professionals Promotion Act of 1991

AHA generally supports H.R.1466, the Allied Health Professionals Promotion Act of 1991 introduced by Representative Terry Bruce. H.R.1466 targets federal support for allied health to specialties or regions of the country where personnel shortages are most acute, with special attention to those fields which play a significant role in the care and rehabilitation of the elderly and disabled. H.R.1466 will help expand existing allied health education programs, create new programs, and address the shortage of qualified faculty. In particular, the legislation would provide for grants and contracts with schools of allied health to assist in the improvement and expansion of educational programs, faculty resources, and to assist in the recruitment of individuals into allied health professions. It also provides grants for schools of allied health for entry level student and advanced training traineeships. AHA urges the committee to consider the provisions of H.R.1466 in its Title VII reauthorization efforts.

National Advisory Council on Allied Health

H.R. 1466 would create a National Advisory Council on Allied Health to advise both the Health Resources and Services Administration and the Congress with respect to the supply and distribution of allied health personnel in the U.S. We heartily endorse the creation of such a commission to provide a regular and comprehensive assessment of health manpower needs, to support the development of national and state level strategies, and to advise on national manpower training policies and federal funding priorities for educational program and student support. Our national reform strategy calls for the appointment of just such a national public/private commission for a comprehensive assessment of health manpower needs.

However, we take strong exception to the proposed composition of the council in Sec. 798A(b)(5) and (6). The proposed breakdown is heavily weighted in favor of the professions themselves, with far too little representation by facilities and training programs. Eight of the proposed members would be members of the professions; five others would represent schools, facilities, insurers, and professional organizations representing the professions. The major employers of allied health professionals would likely be alloted only one seat on the council.

We agree that all these types of entities should be represented, and we recognize the need to keep the council to a manageable size. We recommend therefore that Sec. 798A(b)(5) be revised to limit to 5 the number representing the professions, including national organizations representing the professions, and that Sec. 798(b)(6) be revised to expand to 8 the number representing institutions, providers, schools, and insurers, of which at least three should be health care facilities and providers of health care.

The Rural Clinical Laboratory Personnel Shortage Act

The current shortage of certified technologists and technicians and the continuing decline in the supply of trained technologists are well-known and documented. The number of baccalaureate graduates of medical technology programs declined over 35 percent between 1982 and 1989. During that same period, the number of accredited training programs declined 32 percent, from 639 in 1982 to 436 in 1988. At the same time, there has been growth in the demand for qualified technologists, leading to shortages reported by hospitals. Both the American Society for Medical Technology and the American Society of Clinical Pathologists report high levels of unfilled positions in hospital laboratories. This shortage is most acute in rural areas.

The enactment of the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88), which created a new federal system of laboratory licensure that will apply to all laboratory testing sites, is expected to exacerbate the current shortage of laboratory technologists. The Department of Health and Human Services (HHS) proposed standards for licensure include personnel standards for the supervision and performance of laboratory tests which would exacerbate the already serious shortage of clinical laboratory technologists. The rule would set schooling requirements that would exclude many practicing technologists, worsening the supply problems, and at the same time would increase demand for technologists by requiring that every laboratory have a technologist working as the general supervisor on all shifts when testing is being performed. In addition, once CLIA is enacted these standards will extend to all sites where testing is performed, including physician offices, health clinics, etc., causing an immediate short-term increase in the demand for qualified technologists. This will be a particular hardship for small and rural hospitals where the shortages are already severe.

In the past, HHS was authorized to administer a competency-based examination to recognize the competency of practicing laboratory technologists. This alternative pathway to certification no longer exists, however, and the shortages continue to grow.

In recognition of the dimensions of the current shortage of laboratory personnel, and the likely exacerbation of that shortage, especially for rural hospitals, by the adoption in final form of HHS's proposed standards, Rep. Jim Slattery (D-KS), supported by 44 co-sponsors, introduced H.R.2405, the Rural Clinical Laboratory Personnel Shortage Act, on May 20, 1991.

The legislation offers a two-staged approach to address the shortage and specific problems engendered by CLIA '88. In the short term, to help alleviate the immediate problems for rural hospitals in finding certified personnel, it would require the Secretary to develop, for a limited offering, a new competency-based proficiency examination to recognize individuals currently practicing in laboratories at the technologist level. The competency examination would be To address the shortages in the long-term, the bill would support individuals entering technology programs and would allow them to repay their subsidies by serving in rural laboratory settings, and would stimulate innovative educational programs to bring clinical training to rural areas.

AHA endorses H.R.2405 and strongly urges the committee to include its provisions in its Title VII reauthorization efforts.

Grants for Health Services Administration Programs and Traineeships

Secs. 791 and 791A of the Public Health Service Act authorize funding for grants to accredited health services administration programs and health administration traineeships. These provisions are scheduled to expire on September 30, 1991.

Effective health services administration is essential to the provision of high quality, cost-effective health care services. But the responsibilities of health services administrators go beyond the management of their institutions. As we strive to control health care costs, and ultimately move to national health care reform, administrators will be responsible for managing and implementing organizational and social change on a large scale, while still assuring that necessary services are efficiently provided.

Recognizing the importance of effective health services managers, the U.S. Department of Labor has designated administration as the health career with the largest unmet need of the decade. Key sectors of the health care system continue to report shortages of administrators, including rural health care facilities, community health centers, and managed care programs.

We believe it would be a mistake to allow the authorizations for grants for health services administration to expire. We urge the Committee to continue to support grants for administration by reauthorizing Secs. 791 and 791A at current levels.

Title VIII
The Nurse Education Act

The Nursing Shortage and its Impact on Hospitals

There are now more than 2 million registered nurses (RNs) in the United States, and a full 80 percent are employed as nurses. The supply of nurses has increased by more than 45 percent since 1977, when 1.4 million individuals held licenses as RNs. Despite the increased supply, and the high labor force participation of RNs, a major shortage of nurses developed during the late 1980s and continues today.

The most recent statistics regarding the scope of the nation's nursing shortage come from the American Hospital Association's 1989 Hospital Nursing Personnel Survey. According to this survey, the average hospital vacancy rate for nurses is 12.7 percent, up from previous years. Furthermore, approximately 81 percent of hospitals reported shortages of RNs.

Many factors have contributed to the nursing shortage, such as: a progressive increase in the number of chronically ill and frail elderly patients in need of complex nursing services, increased acuity levels of hospitalized patients, expansion in health care delivery settings which have resulted in an increased demand for nursing services in diversified areas, increased sophistication of medical technologies, and more complex treatment regimens requiring more nursing care.

While a greater demand for nursing services has resulted in more hospitals adding more full-time budgeted RN positions (overall mean percent increase for 1989 was 27 percent according to AHA's 1989 Report of the Hospital Nursing Personnel Survey), the advent of diagnosis-related groups (DRGs) and managed care have forced hospitals to look to more efficient uses of nursing staff. Because of the greater versatility of RNs, many hospitals have eliminated some nonprofessional positions and increased the proportion of RNs on their staff, increasing the demand for RNs.

The shortage of professional nurses coupled with cost containment efforts has resulted in a need for more efficient and effective models of health care delivery. Nurse managers and nurse executives in health care institutions are primarily responsible for effective and efficient delivery of patient care. Nurses must now manage patient care utilizing a limited number of nursing and non-nursing personnel. Because of this, skilled nurse managers have become essential to the effective delivery of health care.

Health care institutions and nurses have responded in a variety of ways to help combat the nursing shortage. The implementation of specific strategies to alleviate the nursing shortage reflects the proactive and collaborative efforts of AONE and AHA to address this problem. AONE recognizes that a shortage of RNs may adversely affect the quality of health care delivered to the American public. With this in mind, AONE has made nurse recruitment and retention a high organizational priority.

Initiatives undertaken by health care institutions and nursing organizations to combat the nursing shortage involve several major strategies: adjustment strategies, which are immediate operational measures such as closing beds, designed to ensure the continuation of appropriate patient care; retention strategies, which focus on efforts to maintain employment of current nursing staff, and recruitment strategies formulated to attract nurses to employment in the hospital setting.

Many hospitals have expanded benefit packages and have found them to be among the most effective nursing recruitment and retention strategies. These include: offering child care; health benefits (medical insurance, sick leave, dental insurance); financial programs (pension plans, tax annuity and savings programs); life-style amenities (housing, on-site dependent care); and offering "cafeteria" plans (where employees can direct the spending of at least a portion of the monies allocated for benefits).

Creating workplace incentives is another strategy used by a majority of hospitals and nursing administrators to recruit and retain nurses. Such programs offer inducements to motivate nurses to continue employment with one institution. Financial incentives, professional enhancement, flexible scheduling, and stress reduction are a few of the different aspects that influence nurse job satisfaction.

Utilization of career ladders, self-governance, performance-based compensation programs, and enhancing nursing autonomy are also strategies that have proven effective in the workplace. Qualified nurse executives and nurse managers play a significant role in initiating and developing incentive programs such as these for nursing staff.

In addition, according to the AHA 1989 Nursing Personnel Survey, a majority of hospitals utilize an educational strategy as part of their recruitment and retention efforts. Two of the most prevalent are tuition assistance to licensed practical nurses (LPNs) enrolled in RN educational programs, and tuition assistance to nurse's aides enrolled in LPN or RN programs. More than 80 percent of all hospitals now offer both tuition reimbursement to full-time RNs who wish to broaden their educational opportunities. Overall, approximately 66 percent of hospitals offer tuition reimbursement to part-time nurses.

Despite these efforts, many of which have succeeded in staff retention, the threat of continued shortages of registered nurses continues. Although enrollments in nursing programs have increased for the first time in several years, today's nursing shortage causes continued concern that the supply of nurses will not keep pace with the demand. The U.S. Department of Health and Human Services, in its Seventh Report to the President and Congress on the Status of Health Care Personnel, projects serious shortages of nurses by the year 2000, even in light of major recruitment efforts by health care institutions.

Reauthorization of the Nurse Education Act

AONE and AHA believe that the responsibility for RN recruitment and retention strategies extends beyond individual hospitals and the health care industry. The federal government can and must assume an active role as well. Federal funding support for nursing education, including student support, fell from $150 million in 1973 to $59 million in fiscal year 1991. AONE believes that Congress must reassert its commitment to fund nursing education. Without such support, our nation cannot be assured that a supply of nurses will be there when needed.

AONE and AHA believe that the 1991 reauthorization of the Nurse Education Act provides an excellent opportunity to address some of the factors influencing the nursing shortage and to provide incentives to individuals to enter the profession and for nurses to remain in the profession. Accordingly, AONE and AHA recommend the following provisions for inclusion in the reauthorization of Title VIII, the Nurse Education Act:

- Increased funding for undergraduate education through the provision of scholarships, stipends, and other forms of student support. Funding for undergraduate education is essential in order to attract individuals into the nursing profession.

- Continued commitment to increased funding for advanced nursing education. Without sufficient numbers of nurses prepared as faculty, nursing education programs will be limited in the number of students that can be accepted.

- Increased funding for and continued provision for the incorporation of demonstrations of innovative practice models, career ladders, and innovative salary and benefit structures in acute and long-term care settings for the purpose of improving retention of nurses in the workplace.

- Inclusion of a provision for funding of continuing and advanced education for nurse managers. Nurse managers play a key role in assuring high quality health care services to the American public. These managers are responsible for directing both professional and nonprofessional personnel involved in health care delivery for groups of patients in health care institutions. Given recent changes in health care delivery, and the shortage of nurses, good nursing management decisions can promote cost-effective utilization of scarce nursing resources. Accordingly, the nurse manager role is critical to the delivery of effective and efficient care delivery.

- Continued support and increased funding for Professional Nurse Traineeships. A vital part of the Nurse Education Act, traineeships provide financial support for nursing students training in clinical specialties at the master's and doctoral levels. These nurses are prepared not only to provide expert bedside care, but also to fill faculty positions.

Conclusion

Existing educational programs in occupational and physical therapy, respiratory therapy, and speech language pathology are neither able to support current personnel needs nor meet increasing demand. With the growing number of elderly and frail elderly, along with advances in medical technology that save and prolong life, demand for additional rehabilitation personnel will continue.

The field of medical technology is, likewise, having difficulty in supporting current personnel needs. However, unlike other allied health professions, the field of medical technology is faced with impending regulations that will not only increase the demand for professionals in this field, but also change the status of many who are currently in practice.

The shortage of registered nurses not only is a problem for hospital staffing, but also may adversely affect the quality of health care delivered to the American public. As the severity of illness of both hospital patients and those in post-acute care settings increases, the demand for additional and more highly skilled nurses will continue to rise. And as new models for delivering efficient and high quality health care introduced, the need for trained nurse managers is more important than ever.

The AHA supports the reauthorization of Titles VII of the Public Health Service Act to provide funding to help alleviate some of these manpower shortages. In addition, we support the legislative initiatives introduced by Rep. Terry Bruce (H.R.1466) and Rep. Jim Slattery (H.R.2405). With some modification to its proposed composition, we support the creation of a national advisory council on health manpower to assess the nation's health manpower needs and to advise the Congress and the Department of Health and Human Services.

Finally, AHA and AONE urge the Committee to use the 1991 reauthorization of the Nurse Education Act to address the factors critical to alleviating the current shortage of nursing personnel.

STATEMENT
OF THE
AMERICAN MEDICAL STUDENT ASSOCIATION

Mr. Chairman, and Members of the Sub-Committee, the American Medical Student Association (AMSA) appreciates this opportunity to present testimony concerning the Title VII programs which fund the education of health professionals and the role these programs play in addressing the nation's health care problems. AMSA is a national organization of more than 30,000 medical students throughout the United States. We are an independent organization committed to the improvement of medical education, the prevention of disease, and equal access to affordable health care.

The increasing costs of education and concomitant rising student indebtedness discourage interested people from practicing in underserved communities such as rural and inner city areas, areas that typically provide less fringe benefits and income to the health care provider. Compounding the situation is the lack of formal training in addressing the health care needs of underserved populations during both undergraduate and graduate medical education.

Introduction

AMSA commends the Sub-Committee's concern about access to health care in this country and the current review of the federal programs provided in Title VII of the Public Health Service Act. Problems with access to health care and health professional shortage areas are well known to the members of this Sub-Committee. Compounding these problems are the increasing health care demands of impoverished children, older Americans, minorities, and HIV infected people. For example, many babies are born without adequate prenatal nutrition and many infants do not receive vaccinations. The American population is aging, but the health care field is not prepared to accommodate this change. There are not enough people trained to meet the specific health care needs of the elderly, either in or out of the hospital setting. The utilization of health care services by blacks since the 1960s has increased, largely due to Medicare and Medicaid. Still, blacks are more likely than whites to receive health care in an emergency room setting, and less likely to have a primary physician. As of March, 1991, there were 171,876 patients living with AIDS.[1] Two percent of those are pediatric cases. The Centers for Disease Control has projected the number of deaths from AIDS in 1991 will reach 43,000 to 52,000, with 56,000 to 71,000 new cases reported.[2] These problems increase each year, and health care professionals are not prepared to administer sufficient health care for these people.

During the early 1960s, the federal government identified a need for increased numbers of physicians. The 1963 Health Professions Educational Assistance Act helped expand the capacity of the health professions educational system. Enrollments almost doubled in the first ten years. They increased from the 1963-64 level of 8,107, to 14,898 by 1975-76.[3]

In the mid 1970s, legislation amending Title VII began to focus on the specialty and geographic maldistribution of health manpower. When the programs were reauthorized in 1976, Congress directed assistance toward projects that encouraged health professionals to practice in medically underserved areas and in the fields of primary care-- Family Medicine, General Pediatrics, and General Internal Medicine.

In 1980, the Graduate Medical Education National Advisory Council predicted a surplus of 70,000 physicians by the year 1990. For this reason, funding for programs designed to assist medical students interested in practicing primary care and working in underserved areas was discontinued. The Council concluded that supply and demand would force adequate numbers of graduating physicians to work in these areas. However, there continue to be problems in the specialty and geographic distributions of physicians. Health manpower statistics released in 1986 by the Department of Health and Human Services (DHHS) show that 14 million people, or 6 percent of the population, live in health professional shortage areas and therefore remain underserved. This is despite an 11 percent increase in physicians since 1980.

AMSA urges the Sub-Committee to continue support of the programs directed at correcting shortages of personnel in primary care and certain geographic areas, and continued support of federal student financial aid programs, including the Health Education Assistance Loan (HEAL) Program. Title VII programs of most concern to AMSA are the Health Professionals Student Loan and Health Education Assistance Loan Programs; the Exceptional Financial Need and Financial Assistance for Disadvantaged Health Professions Students Scholarship Programs; the grants for Excellence in Minority Health Centers and Disadvantaged Assistance Programs; the Family Medicine Departments and Family Medicine Residency support grants; the General Internal Medicine and General Pediatrics Residency support grants; AIDS Education and Training Center grants; and Geriatric Education Centers grants and Geriatric Training and Faculty Development Programs. AMSA hopes the Sub-Committee will extend the current statutory authorities of Title VII for three more fiscal years.

I. Student Financial Assistance

AMSA believes that medical students have a responsibility to contribute as much as they can to the costs of their education, whether through personal and family contribution or through borrowing. We also believe that one's financial situation should not represent a barrier during either the application or admissions process. We believe it is good social policy to ensure that any qualified student-applicant is not prevented from becoming a physician for lack of monies.

During the last decade, medical school tuition has increased dramatically (more than 25 percent adjusted for inflation).[4] At the same time, the amount of money available for education has decreased. In 1978, a student could expect a financial aid package consisting of 37.9 percent scholarships and grants and 61.7 percent loans.[5] Today students rely more upon loans. According to the College Board, in 1988-89 loans constituted 77 percent of the financial aid funds to medical students. The percentage is even higher for osteopathic students. The mean level of indebtedness for medical graduates in 1990 was $45,840, with 75.0 percent of all graduates being indebted.[6] For minorities, the mean indebtedness was $50,944, 94.7 percent graduating with some level of debt.[7]

The time commitment to become a physician is very long. It requires four years of medical school beyond post-secondary school, plus three to seven years of training in an accredited residency program. The course work is so arduous as to prohibit outside employment to meet the high costs of the education. The cost of education is also increased by the need of recent graduates to defer repayment of their student loans through residency. The average salary of a first year intern is $25,000, not enough to make loan payments of up to $1,000 per month.

Without Title VII student financial aid programs, only students from the upper income families will be able to attend medical school. Loan programs such as the HEAL enable middle class students to afford a graduate education. To ensure equal access to medical education for every capable student regardless of family income, the student financial aid programs must have continued support in legislation and appropriations, and these programs must be expanded as necessary to meet the increases in costs and demands. AMSA supports scholarship monies for the underrepresented minority and impoverished students, subsidized loans for students with recognized financial need, and unsubsidized loans for the balance of the costs associated with attending medical school.

Exceptional Financial Need Scholarship. This program should be continued at levels high enough to assist a few students at each institution. Needy students should be eligible for the EFN Scholarship during all four years of medical school. Ideally, the program should be funded at a level adequate to provide assistance for all eligible students. Approximately 75 percent of eligible students do not receive awards for lack of funds.

Financial Assistance to Disadvantaged Students. This scholarship is a much needed source of financial aid to students with exceptional financial need. Approximately 70 percent of eligible students do not receive these funds for lack of resources. We support increased appropriations for this source of financial aid.

These are the only federal scholarship programs provided in Title VII for medical students. Their importance in financing minority education cannot be emphasized enough. These programs have helped increase the number of minority and disadvantaged students who can afford graduate medical education.

Health Professions Student Loan (HPSL) Program. This is a campus-based revolving loan fund that makes low interest loans to students based on need. Medical students must meet the "exceptional financial need" standard. In 1989-90, HPSL provided loans to 7,768 medical students. The HPSL loan is designed to provide funds up to the cost of tuition plus $2,500. Because minimal money has been allocated to the program since 1985, the average financial assistance provided through this program was only $3,965.[8] A recent report from the HHS indicates that despite earlier problems with high default rates, the HPSL program now has a cumulative default rate of only 2.45 percent for all health professions students. This is well within the acceptable default rate limit set by the HHS Secretary.

The HPSL program assists only the very neediest medical students. Additional capital investment in this program is warranted. As students repay their loans, these funds should be returned to the HPSL program and not diverted to the Student Loan Insurance Fund (SLIF), as was recommended by the Bush Administration. AMSA recommends that the Sub-Committee authorize additional funds to this program as well, to support financial assistance to students of the magnitude authorized within this program.

Health Education Assistance Loan (HEAL) Program. The HEAL is a federally insured but unsubsidized market rate loan which is the loan of last resort for students to finance their education. The loan program was designed to cost the government no money. A

Student Loan Insurance Fund (SLIF) financed by premiums paid by borrowers, was established to cover the costs of defaults. However, the insurance premiums were initially too low (0.5 percent) to cover this cost , and the federal government had to appropriate $25 million to the SLIF in FY 1990. In 1985 the insurance premium was increased to 8 percent of the principal. With a current default rate of 8.2 percent, the new premium should cover the cost of future defaults.[9]

Although it is the loan of last resort, many students rely on HEAL dollars to fund their educations. In 1980-81, the percentage of medical students borrowing HEAL dollars was 3.8 percent. In 1990-91, that figure was 38 percent.[8] Recently, one lender, Knight Tuition, had committed all the money allocated to their organization for FY 1991. The current demand is 39 percent above the dollar amount allocated to their organization for FY 1990, with a projected unmet demand of $20 million by October 1991.[11] This is after two supplemental allotments for the Knight Tuition HEAL program during the current fiscal year. Further appropriations are not likely for FY 1991, which will mean a fiasco as classes begin this summer and tuition needs to be paid. During reauthorization of Title VII funds this year, the credit ceiling should be increased above the 1991 limit, rather than decreased to $60 million as recommended by the Bush Administration. An increase in the Stafford loan program annual borrowing limit to $10,000 will decrease dependance on the HEAL program for many students, but the HEAL will remain a necessity for students who otherwise cannot afford to attend medical school.

AMSA opposes the Administration's proposal to limit the credit ceiling and begin phase-out of the HEAL program. This will only further weaken the program, discouraging lenders from participating and making the loan too costly for those who need it the most.

AMSA recommends increasing the number of repayment options available and establishing opportunities for employers to buy out a borrower's loans. AMSA also recommends a subsidy of 1 percent of the interest rate for borrowers who make regular payments during residency (or the first two years of practice for those professions not requiring a residency). This would encourage good repayment habits by borrowers, while decreasing the overall cost of the loan. Together this will decrease the default rate, at minimal cost to the government. At an interest rate of 8.95 percent, a 1 percent subsidy for four years on $10,000 principal would cost $2,500, with a projected 25 year savings of $6,850 for the borrower. Payment of this subsidy can be negotiated between the lenders, the holders, and HHS.

As a further measure to decrease the cost of the HEAL program for borrowers, AMSA recommends an interest cap of 12.5 percent. Should rates exceed this limit, the federal government would subsidize the interest to 12.5 percent, as is already done with the Supplemental Loans for Students program. We also urge Sub-Committee Members to sponsor HR 747, which reinstates deduction of interest paid on student loans during the early years of practice, thereby making loan repayment more affordable. The early years of repayment are when most loans enter into default. Decreasing the costs of repayment during this time period will decrease the default rate. Making loans more affordable will also decrease the economic barriers to practicing in health professional shortage areas.

AMSA recommends creation of a program of loan forgiveness in exchange for provision of health care to Medicare and Medicaid patients. Participants will agree to see a specified number of patients per year in exchange for forgiveness of a certain level of debt, to be paid at the termination of the year subsequent to the terms of the agreement. In contrast to the Indian Health Service, health care professionals would work in an area of their choice, provided these areas contain a sufficient Medicare and Medicaid population. States may also contribute to this loan repayment program under Medicaid reimbursements according to the need for physicians to care for this population of patients.

To counter the high number of defaults resulting from inappropriate administration of various loans by recent graduates, AMSA recommends one standardized deferment form for all DHHS and Department of Education (ED) loans, and the creation of a Central Deferment Office. In this Central Deferment Office, AMSA suggests establishing a branch to act as a Central Borrower-Lender Data Base as a resource of information to borrowers, lenders, holders, and HHS and ED. We also recommend more defined, standardized loan notification forms to minimize the confusion created by the variety of forms that are received by the borrower at various times.

AMSA believes that most borrowers will achieve the financial security necessary to pay the high levels of indebtedness accumulated with this loan program. However, at the time repayment begins, the borrower may not have adequate income, and the loan may enter litigation with ultimate bankruptcy and default. Currently, there is no process for "curing" these loans. Once a loan has entered default, it is always in default despite future efforts of the borrower to repay. We believe that all efforts of due diligence, equal to the measures available in the private loan market, must be exhausted before a loan enters default. Once a loan is paid by the Secretary, all efforts should be made to bring the loan into repayment and "cure" it from the default rate. Given adequate opportunity to repay the loan in this manner, we believe that the 8 percent insurance premium will more than adequately cover the costs of due diligence and cure procedures.

AMSA opposes variable insurance premiums and variable interest rates by discipline according to that discipline's default rate. This would make the cost of the loan prohibitively expensive for borrowers who cannot afford the current costs of the loan and only increase the future default rate. AMSA also opposes imposition of a performance standard for schools participating in the HEAL program. The current method of calculating the default rate for the HEAL program is the method used for the Stafford Loan. Should a performance standard be used, we recommend that the default rate be calculated using the same variables as the HPSL program. As with the HPSL program, HEAL loans should also have a cure process.

We are also very concerned about problems that a performance standard would create for institutions with large percentages of minority students. Minority students borrow more HEAL dollars than do non-minority students, and medical schools with high numbers of minority students have among the highest default rates in the HEAL program. For example, at Meharry Medical College which has above 80 percent minority enrollment, the claim rate for HEAL dollars as of June 30, 1990 was 25.5 percent, with $20 million borrowed. The University of Southern California, which traditionally has very few minority students, had a claim rate of 1.8 percent with equal amounts borrowed.[12] Of the 17 medical schools with default claim rates greater than 10 percent, 12 had minority enrollments well above the national average. Should these institutions be excluded from the HEAL program, the number of graduating underrepresented minorities would decrease, thereby reversing the one of the goals of the Public Health Service Act.

II. Underrepresented Minorities and Disadvantaged Assistance

Title VII attempts to increase the number of underrepresented minorities in medicine. The Bush Administration has requested $31.6 million for the Disadvantaged Assistance Program. This money funds the Health Careers Opportunity Program (HCOP), the government's primary vehicle for minority recruitment in the health professions. HCOP provides grants to schools to support the identification, recruitment, retention, and placement of minority and disadvantaged students in health professions schools. This program has helped increase the applicant pool and reduce the attrition rate of minorities in medical school. Although the number of minority students matriculating to medical school has been increasing at a very slow rate, the number of minority *applicants* has been decreasing. The percentage of underrepresented minorities in medical school is still below each group's representative percentage in the general population.[13] Therefore, these programs deserve legislative support and adequate appropriations for continuation at or above current levels of existence. Support of these programs is consistent with the Administration's goal of improving the health status of racial and ethnic minorities, as minority health professionals are more likely than are non-minority health professionals to work in health professional shortage areas.

III. Primary Care Training Grants

Despite the physician surplus predicted by the Graduate Medical Education National Advisory Council, the number of allopathic and osteopathic physicians choosing primary care specialties declined from 73,489 in 1963 to 67,687 in 1986, and continues to decline. Of these primary care physicians, 45 percent are over age 55.[14] This shortage will worsen, as only 25 percent of allopathic graduates and 40 percent of osteopathic graduates plan to practice primary care. Contrast this with the proportion of primary care physicians in Canada and Great Britain, 50 percent and 70 percent, respectively. Therefore, it is important to support educational programs that emphasize primary care training, since patient fees and research grants cannot support outpatient training in these specialties. The Administration's proposed budget for Title VII funding recommends cut backs in programs designed to support primary care and geriatric training. These programs provide an environment where primary care training can prosper and attract more students to these specialties. AMSA recommends retaining the existing programs for **Family Medicine Departments, Family Medicine Residencies, General Internal Medicine and General Pediatrics Residencies**, and **Geriatric Education Centers and Geriatric Training and Faculty Development**, and providing them with adequate monetary support in FY 1992.

IV. HIV/AIDS Training

AMSA believes that AIDS education should be a fundamental component of medical school curricula and clerkships. AIDS encompasses all areas of health care and transcends cultural, racial, and age boundaries. Managing HIV infection and preventing its spread is the responsibility of all physicians-- surgeons, obstetricians, and internists alike. Therefore, programs like the Health Resources and Services Administration's

AIDS Education and Training Centers (AIDS/ETCs) need continued support from this Sub-Committee, and authorization for continued expansion. Undergraduate health professionals also need to learn how to deal with the special medical, social, psychological, and ethical problems associated with treating AIDS patients. Therefore AMSA recommends expansion of AIDS/ETC to involve the pre-clinical curriculum.

Conclusion

Title VII contains programs that address many of the health problems facing our country: minority recruitment and education, health professional shortage areas, access to care, AIDS education and research, and primary care training. AMSA believes that the programs authorized within the Public Health Service Act help meet the health requirements of the nation, as set forth in the HHS report Healthy People 2000, and deserve continued authorization by this Sub-Committee.

Thank you, and we look forward to working with the Sub-Committee to develop legislation on various Title VII programs in the coming weeks.

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POSITION SUMMARY
AMERICAN MEDICAL STUDENT ASSOCIATION
THE HEALTH EDUCATION ASSISTANCE LOAN
MAY 1991

AMSA believes that the HEAL program remains a vital part of the federal student loan system. However, we recognize that some difficulties exist. The following is a brief summary of AMSA's recommendations on changes that can be made to improve the efficacy of the HEAL program as related to the default rate, loan repayment options and financial aid information disbursement. The enclosed text is an expansion of these recommendations.

I. The High Default Rate

AMSA recommends:

1. The creation of a single deferment form for all federally administered loans and the establishment of a Central Deferment Office.
2. The establishment of a Central Borrower-Lender Data Base to act as a resource for both holders and borrowers.
3. Standardization of loan notification forms to eliminate administrative confusion.
4. Establishment and enforcement of due diligence and cure procedures.

II. Loan Repayment Options

AMSA recommends:

1. Increasing the number of options available for loan repayment schedules, including repayment based on percentage of income.
2. Establishing opportunities for employers to buy out a borrowers student loans.
3. Residency program participation in student loan repayments.
4. Offering a reward to borrowers who participate in an early repayment schedule.

III. Financial Aid Information Disbursement

AMSA recommends:

1. Offering a standardized training program for all financial aid officers.
2. Offering borrower counselling just prior to the start of repayment.

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POSITION
AMERICAN MEDICAL STUDENT ASSOCIATION
THE HEALTH EDUCATION ASSISTANCE LOAN
JUNE 1991

Background:

The Health Education Assistance Loan (HEAL) is a federally insured loan program authorized under Title VII of the Public Health Service Act. 8% of the initial principal is deducted before disbursement and contributed to an insurance fund known as the Student Loan Insurance Fund (SLIF). The interest rate is set at 3 percentage points above the T-bill and begins to accrue at the time of disbursement. Interest may be compounded annually or biannually according to the terms of the lender. The borrower can defer payments on the principal and interest of the HEAL loan during a 9 month grace period after graduation and up to four years while in an accredited residency program. In this instance the interest may be added to the principal balance at the discretion of the financier. Finally, the loan is repayable over a period of either 10 or 25 years.

In fiscal 1990, 12,635 students (40.7% of borrowers) at allopathic medical schools borrowed a total of $107 million (39.5% of total HEAL dollars). During the same year, 4,311 students (13.9% of borrowers) at osteopathic schools borrowed a total of $46 million (17.0% of HEAL dollars). The total number of HEAL dollars lent in fiscal 1990 was $270 million to a total of 31,071 borrowers. The medical students totaled 54.6% of HEAL borrowers and used 56.5% of HEAL dollars. Medical student borrowers contributed a representative amount of $12.2 million to the SLIF in 1990. The Department of Health and Human Services (DHHS) states that 38% of medical students have HEAL money included in their financial aid portfolio.

AMSA recognizes that the original purpose of the HEAL program was to make money available for health professional students, at no cost to the federal government. The loan was designed to allow capable students, with needs beyond the scope of existing grant and loan programs, to obtain an education in the health professions. The HEAL loan is the "loan of last resort" and was designed to be completely self sustaining. We believe that while there are significant problems in the program, the HEAL is of tremendous importance to medical students. Phase out of the HEAL program is not warranted at this time, but improvements are necessary to alleviate some of the difficulties. Specific problems which need to be addressed include the high default rate, the high cost of the loan to the borrower which we feel contributes to the high default rate, and various administrative complications.

I. The Default Rate

In 1990, the government paid $26.1 million in HEAL default claims. Amounts paid for borrowers from allopathic schools totaled $6 million or 23% of total default dollars and $2.8 million from osteopathic schools or 10.7% of total default dollars. The total default rate was calculated at 7.7% of borrowers and 9.7% of disbursed dollars. 4.3 % of borrowers who attended allopathic medical schools defaulted on their HEAL loans. The default rate was 4.8% for those who attended osteopathic schools.

Although medical students borrow a large amount of total HEAL dollars, the percentage of medical student borrowers in default is low. However, students of the medical profession account for a large portion of default dollars due to the size and numbers of their loans. The amount of money owed by medical student borrowers at the time of repayment reflects the high cost of medical education and the length of time to licensure. As students rely increasingly on HEAL dollars to fund their education, the number of loans in default may change. The 1990 claims for all medical students, although still significantly smaller than the claims paid for other disciplines, is more than double the dollar amount of claims paid in 1989.

There are several factors contributing to the high default rate among physician borrowers. Technical default, defaults arising from incorrect administration of deferment forms, makes a significant contribution. In 1990 the Association of American Medical Colleges matched the list of allopathic physicians in default with its list of physicians enroled in residency programs. They determined that over 60% of the defaults of loans held by allopathic physicians should have been listed in deferment secondary to enrollment in residency training programs. Somewhere in the paperwork process and confusion that accompanies graduation from medical school, relocation and starting a residency, the borrower encounters difficulties and fails to send the appropriate forms to the correct institutions and servicers.

Other administrative complications exist. A significant number of defaulters made good on the loans after the time of litigation. This would indicate that failure to repay may have been due to a communication failure in the notification of due payments, inaccessibility of the borrower to the holder, or other misunderstandings between the holder and the borrower. Loan portfolios for health professional students tend to be very diverse, and this increases the borrower's misunderstandings of his loans. Managing repayment of all the different loans requires good administrative skills, in addition to adequate income.

Insufficient income in the first years of repayment also contributes to the high default rate. All education loans taken by physicians come due either during residency training or during the early years of practice. Considering that the HEAL is the "loan of last resort," borrowers will have multiple other loans of substantial size which come due either before or at the same time as the HEAL loan. These payments may be as large as $750 to $1,000 a month. The salaries earned by residents in the last years of residency are rarely more than $33 thousand. Payments of this caliber are simply not possible on an income of this size.

Currently, there is no cure process for HEAL loans. Once a borrower becomes established, he may enter repayment on previously defaulted loans but these loans remain within the default statistics. The DHHS should establish a means by which these borrowers can be cured from the default calculations. Furthermore, HEAL regulations should include due diligence processing equivalent to that for the Health Professional Student Loan or the private loan market.

Although it is impossible to completely eliminate the defaults a number of steps may be taken to decrease the rate of default.

Recommendations:

1. Single Deferment Form and a Central Deferment Agency

Currently there is a great deal of confusion concerning the submission of deferment forms. Individuals who borrow from multiple programs must fill out a separate form for each program. Each form may have specific information requests and all must be signed by the residency program director who must then forward it to the appropriate agency. For the borrower who uses multiple lenders and multiple loans, there may be 10 or more deferment forms involved. All this paper-work creates a number of places where the process can break down, for any of the different loans, leading to technical default.

AMSA recommends the creation of a single multiple copy deferment form and a Central Deferment Agency to help alleviate the problem of technical default. A single multiple copy form can be designed with sufficient information to satisfy the needs of the various programs, including both Department of Health and Human Services (DHHS) and Department of Education (ED). Once the student has filled out his section, he would forward the form to the Director of the residency program as is currently done. The Director would verify the borrower's enrollment in the program and redirect the appropriate copy of the form to a Central Deferment Agency.

The Central Deferment Agency would be a federally administered office responsible for informing the loan holders, the loan servicers, and DHHS and ED of the borrower's status. This agency would be responsible for notifying the borrower when his loans enter into deferment. By simplifying the process, technical defaults due to incomplete administration or complete failure to submit forms would be diminished.

2. Central Borrower-Lender Information Data Base

To alleviate the defaults due to other failures in communication between the holder of the loan and the borrower, **AMSA recommends establishing a central data bank containing the following information:**

a. The borrower's name, address, and telephone number.

b. The name, address, and telephone number of two other people who know where to reach the borrower.

c. The name, address and telephone number of the school from which the borrower received his/her degree or which the borrower most recently attended.

d. The borrower's (expected) year of graduation.

e. The name, address and telephone number of the borrower's residency program.

f. The name, address and telephone number of all holders of the loans used by the borrower.

g. The type of loans, with the year disbursed, the principal, and interest rate of each, current status of the loan, and when repayment begins.

When there are difficulties in communication between the borrower and holder, either one may access this data bank for the purpose of improving communication and obtaining this centralized information. As is the case currently, to update the information, the borrower would have to request a new form and fill out the appropriate section(s).

3. Standardized Notification Forms

Standardized notification forms would also eliminate a lot of administrative confusion for the borrower. Currently many forms contain vague information concerning the terms of the loan, the bank from which the loan was borrowed, the interest accrued, repayment dates, etc. **AMSA recommends a biannual distribution of a standardized loan notification form which would contain the following information:**

a. The name, address and phone number of the holder.

b. The type of loan, date and amount of disbursement.

c. The interest rate.

d. The amount of interest accrued.

e. The compounding schedule.

f. The date repayment begins.

g. The expected monthly payment.

h. The breakdown of interest to principle per payment, based on an amortization schedule.

i. The current deferment status of the loan.

4. Due Diligence Procedures

While most borrowers do not have adequate income at the time repayment begins to fulfill their monthly obligations, most will achieve the financial security necessary within a few years. However, when repayment begins, if the borrower does not have adequate income, the loan may enter litigation with subsequent default. Currently there is no process for curing these loans. Once a loan has entered default, it is always in default despite future efforts of the borrower to repay. **AMSA recommends that all methods for collection on a loan, equal to those used in the private loan market, be exhausted before a loan enters default.** Additionally, once the loan is paid by the Secretary, **all efforts should be made to bring the loan into repayment and cure it from the default rate**. Given the opportunity to repay the loan in this manner, we believe that the 8% insurance premium will more than adequately cover the costs of defaults and due diligence and cure procedures.

II. Loan Repayment Options

As noted earlier many defaulters demonstrate insufficient income at the time of default to make loan repayments. AMSA believes that expanding the options in loan repayment will help alleviate the problems associated with inadequate income.

1. Expanding Options For Loan Repayment Schedules

When loans initially come due, physician borrowers are often in residency training or entering into the first years of practice. During these years borrowers have a high debt to income ratio even though they will earn sufficient income later to make complete and timely payments. Because of the high debt to income ratio, loan repayments become burdensome or even impossible.

AMSA recommends that borrowers be given additional repayment options based on projected income. For example, by graduating the loan repayment schedule based on a percentage of income rather than a flat rate, borrowers could repay to the extent that they are capable. As the borrower's income increases, the monthly payments will increase proportionately. Alternatively, the percentage of income due could increase as total income increases. All repayment schedules still are to be completed in 25 years. These options are a few of the variations that could be arranged.

2. Employer Loan Buy Outs

As an incentive for physicians to work in primary care field in underserved areas, **AMSA recommends that employers be given the opportunity to pay a borrower's HEAL debt, provided the employers agree to reduce the interest rate on the loans**. The administration of such a program may be handled through the employer or it may be contracted out. Accordingly, the borrower would make payments to the employer directly or to the servicer. The federal government would continue to insure the loan. The decreased interest rate on the loan will serve as a recruitment tool for employers, particularly those in underserved areas who are looking for primary care practitioners. Ultimately, this plan lessens the cost of medical education.

Also, a community could offer to repay the loan in part or entirely in return for a service contract. This option acts as an incentive for borrowers to work in communities which have the most need for physician services. The agreed on terms of the service contract would be left to the community and the borrower.

3. Residency Program Involvement in Repayments

Loan repayment arrangements could act as an incentive for primary care residency programs to attract students whose level of indebtedness might otherwise direct them towards the better paid tertiary care subspecialties. Medical students consistently steer away from the primary care specialties at a time when many of the already practicing physicians are retiring. As a result of this trend, the shortage of primary care practitioners continues to grow rather than diminish. Primary care specialties typically earn significantly smaller salaries than the highly technical tertiary care subspecialties. Moreover, the cost of medical education continues to rise, and medical student debt rises with it. The high debt to income ratio serves as a disincentive to students who might be interested in primary care. By encouraging residency programs to offer loan repayment options, that disincentive may be diminished.

AMSA recommends encouragement of residency program participation in student loan repayment. There are multiple possibilities for loan repayment. A lump sum bonus could be paid directly to the lender in the name of the interns and residents, at the start of each year. Payments may be made on a monthly basis directly to the borrower. Or additional sums of money could be added to the participant's salary as a bonus for repaying student loans. The amount of the repayment bonus may be a topic of negotiation between the institution and the resident.

There are additional benefits in encouraging residency programs involvement in the student loan repayment plan. For the loan holders and the federal government, there is a diminished chance of default with all of the financial and administrative benefits expected. Moreover, a mechanism for loan repayment at this juncture would create a place to offer financial counselling to the borrower. For the borrower, early payments on the loan diminish the ultimate financial commitment. And it gives the residency program a strong recruiting tool.

4. Incentives for Early Repayment.

As the loan system currently exists, borrowers are discouraged from defaulting rather than encouraged to pay. The incentive for repayment is lack of punishment. **AMSA believes that rewards for diligence and early repayment would promote good borrowing behavior and early retirement of debt, to the benefit of the borrower and the federal government.**

For example, the federal government could offer a subsidy of 1 interest point on a loan to borrowers who made regular payments during residency. In order to receive this benefit, borrowers would be expected to repay a specified minimum monthly payment, possibly $50 to $100, for the duration of their post graduate education (See ATTACHMENT A). Alternatively, the reward system could focus on early repayment after residency is completed. A young practicing physician could agree to retire the loan in a shorter period of time in exchange for a cut in his interest rate. AMSA believes that this type of reward system will encourage borrowers to develop good repayment habits. Moreover, a cut in the debt burden benefits the federal government by potentially diminishing the default rate.

III. Financial Aid Information Dissemination

The federally administered loan programs are complicated and confusing. A borrower's only contact with the loan system is often the medical school loan counselor, who acts as a gate-keeper by advising the borrower on the best loan package. While borrowers receive information throughout their undergraduate training and at an exit interview, the information concerning repayment schedules is sometimes incomplete or offered at inopportune times: i.e. years before the actual start of loan repayment. When the borrower begins to examine his loan repayment situation, he is often confused and wastes a great deal of time working out loan repayment schedules and options which are compatible with his income. The previous sections contained comments on the administrative aspects of information disbursement. This section will contain some recommendations on the format of information dissemination.

1. Financial Aid Personnel Counselling

The system of federal loan programs is complicated, and eligibility for loan packages varies from school to school. Financial aid officers are the borrower's major contact with the federal student loan system and serve as a major source of information. Moreover, it is the financial aid officer who is responsible for determining, according to federal guidelines, which students are eligible for various loan programs. There is no specific training process for financial aid officers, which often results in an information gap concerning the availability and terms of loan programs. Ultimately, borrowers may not receive the most desirable loan package which may result in a significant increase in the cost of their education.

Because the financial aid office is so critical to obtaining the most equitable loan package, **AMSA recommends the establishment of a federally administered financial aid officer training program**. The program would offer financial aid officers information on each of the loan programs, the criteria for qualification for the programs, and information concerning the administration of these programs. By establishing a more educated loan officer pool, AMSA believes that borrowers will use federal loan programs more wisely and will receive better loan packages. In addition, unintentional misuse of federal loan programs due to unclear information will decrease. Both the borrower and the federal government will ultimately spend less on medical education as a result.

2. Borrower Counselling

Currently borrowers using the student loan programs are required to receive counselling both upon receiving the loan and during the exit interview just prior to graduation. This counselling is necessary to educate borrowers on all issues related to student loans and some of the issues related to loan deferments. However, in terms of actual loan repayment, it occurs too far in advance. Much of the information exchanged at these interviews about the specifics of loan repayment schedules is lost or forgotten by the time the borrower needs to use it.

AMSA recommends that additional counselling between the holder and the borrower take place shortly before loan repayment is scheduled to begin. The counselling need not take place through a meeting. Telephone and/or mailing information may be adequate, provided there is proof that the borrower has received the information. The holder of the loan knows the most about the borrower's debts and repayment possibilities. Therefore, it is logical that the holder be responsible for the dispersal of information concerning the specifics of the borrower's loan repayment schedule.

The counselling program should include the following information:

a. The type and number of loans the borrower holds.

b. The amount of principle and accrued interest.

c. The interest rates and compounding schedules.

d. Possibilities for loan repayment schedules.

e. Possibilities for loan consolidation.

f. The amount of monthly payments, including the breakdown of interest and principle.

g. The name, address, and phone number of the holder.

Amsa believes that counselling offered in a timely fashion will increase prompt repayment and diminish confusion related to unclear repayment schedules. Moreover, it will permit borrowers the opportunity to arrange repayment schedules which will more adequately fulfill their needs.

Conclusion:

With these improvements to the HEAL program, AMSA believes that the federal government can continue to assist qualified people as they pursue careers in the health professions. Without this program, AMSA has reason to believe that many professional schools, especially those that are rely on tuition for support rather than research grants, will close. For a number of years, AMSA has attempted to establish a privet loan market for our student members. We have not been able to find private investors or investors within the banking and insurance industries. The Association of American Medical Colleges has established a private loan market (MED Loans), but has expressed concern over decreasing capital for future borrowers and problems meeting current demands. Any chance that AMSA or other organizations has will be jeopardized by a breakdown in the government guaranteed market, for obvious reasons. Therefore AMSA recommends reauthorization of the HEAL program with adequate borrowing ceiling to allow adequate support of the health profession students.

For more information concerning AMSA's position on improvements for the HEAL program please contact:

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ATTACHMENT A

SUBSIDIZED HEALTH EDUCATION ASSISTANCE LOAN

RATE COMPARISON DURING RESIDENCY

Annual Amount	$10,000
Number of Years	4
AMSA interest rate during residency	8.95%
AMSA subsidized interest rate during residency	7.95%
Interest accrued during residency	$19,625.02
Interest accrued during subsidized residency	$17,125.67
Cost to subsidizer	$2,499.35
Overall savings to the student over 25 years of repayment	$6,844.55

Source: Knight Tuition Payment Plan. The savings to the borrower only include the cost of the subsidized interest. The savings are further increased by the monthly interest payments made under this plan.

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June 10, 1991

The Honorable Henry Waxman, Chairman, and Subcommittee Members
Health and the Environment Subcommittee of the Energy and Commerce Committee
512 House Annex I
Washington, DC 20515

Dear Mr. Chairman and Subcommittee Members:

On behalf of the American Physical Therapy Association (APTA), a national membership association representing 51,000 physical therapists, physical therapist assistants and students of physical therapy, I wish to submit the following comments on the reauthorization of Title VII of the Public Health Service Act. Specifically, the APTA is very supportive of H.R. 1466, the Allied Health Professions Promotion Act of 1991, introduced by Representative Bruce.

As the Subcommittee is aware, the nation continues to face serious shortages of key medical rehabilitation professionals, with the most dramatic needs being in physical therapy. Many facilities including hospitals, nursing homes, home health and rehabilitation agencies and other service providers are increasingly unable to recruit sufficient numbers of physical therapists. The skills and services of these practitioners are critically important in the provision of care to the elderly, the chronically ill and individuals with disabilities.

The following illustrates some of the current/projected statistics for the physical therapy profession:

The Shortage of Physical Therapy Personnel

- Based on current data, there are an estimated 71,000 licensed physical therapists in the United States today. Of the 71,000, 70% (49,700) work full-time, 23% work part-time and 7% (4,970) are retired or not working. Thus, the current work force is estimated to be 66,030.

- The Bureau of Labor Statistics has projected that physical therapist positions will increase by between 48% to 62% by the year 2000. If one takes the Bureau's moderate percentage increase of 57%, then this means that the number of positions should increase by 39,000 over the 1988 figure of 68,000 positions. In other words, there should be approximately 3,250 new positions added to the market each year for the next twelve years.

- Approximately 4,200 new licensees entered the physical therapy work force last year. An estimated 2.4% of the total work force (1,585) leave practice every year to attrition. This results in an annual gain in the total work force of 2,615 physical therapists. We predict, based on the current numbers of enrolled students, that the demand will continue to outstrip the supply.

Demand

- The practice settings experiencing the greatest shortages are rehabilitation centers, hospitals, schools, nursing homes, and home health agencies. It should be noted that patients of all age ranges are included. The surveys conducted in several states (Georgia, Maryland and New York) indicated that a 15-19% vacancy rate for physical therapists exists in these settings.

- Research conducted by the APTA has shown that the application to acceptance ratio in physical therapy entry-level education programs is nearly 5:1. Thus a large number of qualified students are adversely affected by a lack of funding. If funds were available to increase enrollment, greater numbers of physical therapists could be graduated to meet the demand.

- Physical therapy education is experiencing a short-fall in qualified faculty. The final report of The Task Force of Faculty Shortage (November 1985), funded by the APTA, predicted that an additional 300 faculty prepared at the doctoral level will be needed to teach in physical therapy entry-level education programs by 1997. This number did not account for increases in the number of programs or increases in the number of students enrolled. Consequently, the number of faculty must be increased beyond this figure to meet the increase in class sizes necessary to graduate the additional therapists to meet the demand.

- The number of full-time physical therapy faculty has increased since 1985. However, the number of vacancies has increased from 66 in 1985 to 104 in 1990 and is projected to increase to 105 vacancies for the academic year 1990-91 representing a 12% vacancy rate. In addition, the number of new programs in institutions previously without physical therapy education programs has increased, further expanding the need for new faculty. See enclosed article for additional details.

Based on these statistics, it is obvious that the number of available physical therapist positions far exceeds the current supply of graduates from physical therapist education programs. The solution to the inadequate supply problem is to increase the number of physical therapists by expanding the number of faculty and the class size in existing programs. A solution lies in the passage of H.R. 1466, the Allied Health Professions Promotion Act of 1991.

The Bruce bill provides a much-needed authorization for expansion of faculty and program resources and entry-level student traineeships. The APTA is particularly supportive of the provision which earmarks 75 percent of this proposed funding for those allied health professions with the most significant national/regional shortages and who play a significant role in the care and rehabilitation of the elderly or disabled. This is certainly the most efficient allocation of funding because it would benefit those allied health professions with the greatest needs.

The bill also provides funding for the advanced training of allied health personnel, which would assist with increasing the number of faculty and an Advisory Council on Allied Health, which would have eight members from allied health professions on it who could advise and make recommendations to the Department of Health and Human Services. The APTA believes that both of these provisions would be very beneficial.

For fiscal year 1991, Congress authorized $6 million and appropriated $1,659,000 to be used for grants for allied health faculty and program development. This is only the second time since 1980 that funding has been appropriated for this purpose; it does not begin to meet the funding needs of physical therapy and the other allied health professions. As proof, the Bureau of Health Professions received 124 grant proposals for FY 91 (49 had physical therapy components) and will only be able to provide funding for 17 of them.

As you did with the nursing profession, the American Physical Therapy Association urges your support for H.R. 1466 at the full authorization levels. We do appreciate your interest in physical therapy and the other allied health professions.

Sincerely,

Pamela Phillips
Associate Director, Government Affairs

Enclosure

INTERVIEW

Faculty Issues

By Ellen N. Woods
Editor, Progress Report

As the demand for physical therapy services increases, the shortage of faculty to educate future physical therapists and physical therapist assistants becomes more and more of a priority issue for the profession. When Rose Sgarlat Myers, PhD, PT, joined APTA in 1984 as associate director of Education, her first assignment was to prepare for meetings of the Faculty Shortage Task Force. In the seven years since this group completed its work, APTA has worked hard to address issues related to the faculty shortage, such as recruitment, retention, and development. In the following interview, Myers offers her thoughts on faculty matters.

Rose Sgarlat Myers

***Progress Report*: Why has the faculty shortage become such a priority issue for the physical therapy profession?**

Myers: In order to have a physical therapy education program at all, you must have faculty with appropriate credentials and enough faculty to develop and maintain a high-quality program. In addition, if programs are going to be in colleges and universities, your faculty must be capable of being promoted and achieving tenure.

The doctoral degree has become one of the basic credentials for faculty in higher education. Additionally, the faculty member must be able to design, conduct, and report research. They must study, synthesize, analyze, and interpret the literature to create new knowledge in a scholarly fashion. Even the smaller liberal arts colleges are basing promotion and tenure on the research productivity of the faculty.

Physical therapy has fallen short in this area and this is why the faculty shortage is such an important issue. Many physical therapy faculty don't have the appropriate credentials or skills that I just mentioned. They haven't earned a doctoral degree and they have not been part of the research community. That's not a knock on the profession or the faculty. Look at how we began. Many of our programs were in hospitals and/or were certificate-level programs. So for a young profession, it's understandable that we haven't had a higher-level research base.

What has called attention to the faculty shortage in the last few years is not only the lack of credentials of our faculty as a whole, but the tremendous increase in the number of physical therapy education programs. That relates to supply and demand. It's pure and simple. We've certainly increased the number of faculty since 1984, which I use as a base year. That was the first year APTA's Faculty Shortage Task Force met. The number of people holding doctoral degrees has increased rather dramatically as well. We just have not been able to keep up with the demand. In 1970, there were 48 institutions with physical therapy education programs. Today, there are 131 programs in 119 institutions with 102 full-time faculty vacancies in accredited programs. There are an additional 17 developing physical therapist programs. (See chart below.)

APTA DEPARTMENT OF EDUCATION
Faculty Physical Therapist Education

Years	Programs Institutions	Faculty Full-time	Faculty Doctoral	Vacancies	Projected Vacancies
1983-4	108 (102)	626	149 (25%)	59 (9%)	
1984-5	112 (105)	654	183 (28%)	62 (9%)	
1987-8	121 (113)	645	218 (34%)	95 (13%)	
1988-9	125 (115)	722	254 (35%)	80 (11%)	101
1989-90	125 (116)	779	298 (38%)	104 (12%)	102

In February 1991 the Department of Accreditation reports the following:
Physical Therapist DEVELOPING PROGRAMS = 17
Candidates (4)
Submitted a Declaration of Intent (6)
Hired a Chair (7)

***Progress Report*: How many faculty members are necessary to adequately staff a physical therapy education department?**

Myers: In my opinion, you need nine full-time faculty members. This includes an academic administrator, an academic coordinator of clinical education, and seven faculty members. You need a class size of 40 students to support a program. Now that's my opinion. I know that some people will say 'Well, you can get by with a number of part-time clinicians.' But you may burn out your full-time faculty. Part-time faculty come in to teach a course and that's usually it. They are not there to advise students or to do the admin-

See ***Interview*** page 18

Interview (from page 1)

istrative work of a department, such as participate on an academic curriculum committee or a promotion and tenure committee.

In addition, part-time faculty typically don't have the academic credentials for higher education. That's why physical therapy departments don't have as much stature in the universities as the physics department or the medical school. Also, if you have overworked faculty, it's very difficult for them to be part of the university community and to contribute to scholarly research.

That's why I believe you need seven full-time faculty members, and that's not happening in most schools. This is not to say that clinicians as part-time faculty aren't valuable. I don't think we should [illegible] We just shouldn't be relying solely on them to solve the faculty shortage.

***Progress Report*: What has APTA done to help solve the faculty shortage?**

Myers: APTA's Faculty Shortage Task Force met in 1984 and made recommendations to the Board of Directors and to the physical therapy education community. The Board incorporated many of the recommendations into the Five-Year Plan For Post-Baccalaureate Entry-Level Education. This plan addresses major issues of faculty development, recruitment, and retention.

The Five-Year Plan also calls for 1% of membership dues to be allocated for faculty development. This money goes to the Foundation for Physical Therapy's doctoral education [illegible] part of the administrative fee from APTA-sponsored insurance programs to go to this fund. Last year, the Association contributed about $110,000 to the Foundation for doctoral training.

The Board also funded a retreat on doctoral education, which met in September 1989. It was attended by faculty from physical therapy graduate programs. The group made recommendations to the Board. The Board then appointed a task force that took many of the recommendations and developed a plan to strengthen the doctoral programs in physical therapy and to increase the number of students enrolled. The plan was approved in November, and its main intent is to recruit students from entry-level and post-entry-level programs who are potential faculty members.

Staff members have worked with various agencies, Congress, and state legislators and have testified in support of faculty-related issues. In addition, staff have assisted with legislation, such as Title VII, which includes funds for faculty development and recruitment.

We've also held conferences on issues relating to the faculty shortage, developed publications on graduate programs for physical therapists, and continued to collect data and advise members about academic appointments and graduate education.

***Progress Report*: Can you tell us about any institutions that have developed innovative programs for recruiting, developing, or retaining faculty?**

Myers: I don't know if I can pinpoint any one school or individual because so many are working so hard to solve these problems. But I can tell you about some of the more common practices. Many institutions have hired faculty who have master's degrees and then funded and supported the faculty member through graduate school. By seeing those people through their doctoral work, the institutions are developing their own faculty.

One institution has developed a traineeship for non-physical therapists holding a doctoral degree in another discipline. During the traineeship the student completes an entry-level physical therapist program and participates in physical therapy research. Most of the students completing this program have become physical therapy faculty members.

"I would like to see a significant number of students enter physical therapy entry-level education programs with an academic career in their plans."

Some schools that are affiliated with hospitals have a cooperative agreement with hospital clinical staff who teach part-time. Others share faculty between institutions in the same city. There are also a growing number of faculty practice programs. Although this option is not possible in every institution, it is a nice way of adding incentive for faculty. It also gives faculty a clinical outlet to expand their competence and can stimulate clinical research.

By and large, what most schools have done is hire clinicians in specialty areas to teach one or two courses. Of course this doesn't really fall under the category of innovative because we have been hiring our colleagues on a part-time basis for decades.

***Progress Report*: What do APTA and the profession have to do in the next few years to address the faculty shortage?**

Myers: We, as a profession, must [illegible] faculty. Current and potential faculty need to obtain their doctoral degrees and prepare for scholarly careers.

Physical therapists who have earned certification in a specialty area need to become an integral part of the education community—not necessarily full time, but on a permanent part-time basis. They can combine clinical practice with a dedication to teaching and research, and, in effect, become clinical scientists.

APTA needs to convince federal, state, and other appropriate agencies to make funds available for faculty development. And we need to continue to provide funding for doctoral training through the Foundation or through other means. APTA will also continue to provide information on faculty activities, research, and other relevant information.

In addition, the main emphasis should be on recruiting new students for doctoral education in physical therapy. Through this mechanism the profession should develop an ample supply of doctorally prepared members to assume faculty positions in the entry-level and graduate programs. This of course means that we must recruit students into the entry-level programs who have an academic career in mind. These students must be carefully mentored and nurtured as they progress through the entry-level and graduate program.

***Progress Report:* If you could paint an ideal picture of the next five years in regard to the faculty shortage, what would you see?**

Myers: I would like to see 65% of the physical therapy faculty members prepared at the doctoral level and beginning a research career if not already involved in research. I would like to see larger entry-level programs with greater numbers of faculty and students. I would also like to see an increase in the number of doctoral programs. Most importantly, I would like to see a significant number of students enter physical therapy entry-level education programs with an academic career in their plans.

And finally, and this is really pie-in-the-sky, I would like the external community to realize that APTA has not created the shortage to raise salaries. APTA has put a lot of time and funds into increasing the number of faculty, which in turn will help increase the number of physical therapists. What people must realize is that the shortage has come about because the scope of physical therapy has expanded in the last few years and the population as a whole has realized the advantage of physical therapy in improving the quality of life. This is what has created the tremendous demand for our services.

I would invite others who benefit from physical therapy, and this includes hospitals and intitutions of higher education, to join us in solving the faculty shortage.

(If you would like to discuss faculty-related issues with Myers, you can call her at 800 999-2782, ext 3200.)

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges (AAMC) appreciates the opportunity to submit our recommendations for the reauthorization of Title VII of the Public Health Service Act. The AAMC serves as the national voice for our nation's 126 medical schools, 420 teaching hospitals, and 90 academic and professional societies whose members seek to promote public health by providing leadership on policies to educate 60,000 medical students, train the 68,000 residents in graduate medical education programs, develop advances in medical knowledge and improve the delivery of health care.

The AAMC strongly believes the programs under Title VII of the Public Health Service Act should receive full reauthorization. The AAMC shares the Subcommittee's concern about access to health care in this country and commends the current review of the expiring federal programs in Title VII that serve to expand the availability of primary care physicians and other health professionals. Since the enactment of the Health Professions Education Assistance Act in 1963, federal health manpower assistance policy has shifted its original emphasis of increasing, in the aggregate, the national supply of health manpower to improving the geographic and specialty distribution of health care professionals. Overall supply considerations have now been replaced with a special focus on the absence of primary care physicians, particularly in many rural and inner-city areas and the underrepresentation of minority students in the health professions. It is clear that an enhanced federal commitment to Title VII programs is crucial to support the goal of improving the nation's health.

The Title VII programs of greatest concern to the member institutions of the AAMC are those programs concerned with student financial aid, minority and disadvantaged recruitment and retention, primary care residency training, and the programs that address geographic and specialty needs, such as Area Health Education Centers (AHECs) and Geriatric Education Centers (GECs).

Student Financial Assistance

For medical schools and students, rising levels of educational indebtedness is a pressing problem. The AAMC is concerned about the effect high levels of debt may have on access to medical education, the extent of repayment burdens, and the frequency of loan defaults. Decreasing availability of grants and scholarships has exacerbated the medical student's debt burden, particularly for the most needy students. For the vast majority of students, loans are the primary source of financing medical education. Seventy-nine percent of 1990 medical school graduates borrowed to finance their education. This group of students would have found it very difficult, and in many cases impossible, to finance their education without the Health Education Assistance Loan (HEAL) and federal guaranteed student loans administered by the Department of Education.

As borrowing has become the chief vehicle for financing medical education, the recent escalation in levels of educational debt has received greater attention. Indebtedness among graduates of medical school has increased almost 200 percent in the last decade. The average 1990 total debt (including medical and pre-medical loans) of medical school graduates who borrowed to finance their education was $46,224; over twelve percent of graduates had debt in excess of $75,000. Minority students acquired a higher average debt of $51,000; 21 percent graduated with debt in excess of $75,000. Medical educators and financial aid administrators are concerned that these debts are becoming unmanageable for many borrowers, particularly in the first few years of repayment when a significant number of physicians are in residency training programs. A medical school graduate must complete a residency training program, lasting between three to seven years to be eligible for board certification. During this period, medical residents earn annual stipends ranging from $25,000 to $35,000, depending on their residency year and region of the country. Clearly, a recent medical school graduate's debt-to-income ratio makes loan repayment very difficult during their postgraduate training and early years of practice.

Data collected each year by the AAMC through its graduate questionnaire indicate that debt level is not a major factor in decisions about specialty choice. While AAMC data do not show a clear relationship between debt level and specialty choice, the medical education community is concerned that indebtedness may be affecting decisions about whether to pursue professional education and about the impact high debt may have on loan defaults. Without Title VII student financial assistance programs, many disadvantaged, minority, and middle-income students would not be able to pursue the study of medicine. To uphold the goal of equal access and to ensure that every capable student, regardless of income, has an opportunity to attend medical school, the federal student financial aid programs must be continued and expanded.

The AAMC strongly recommends that the **Exceptional Financial Need Scholarship** program be authorized at levels high enough to provide grant assistance to help meet the financial needs of a greater number of minority and disadvantaged students. For FY 1991, the program received $9.8 million. In the 1989-90 academic year, medical students received $3 million in federal funds for EFN scholarships which provided assistance to only 532 students (fewer than one percent of all medical students), with an average award of $5,639. The AAMC recommends an authorization level for FYs 1992, 1993 and 1994 of $12, $15, and $18 million to increase the number of scholarship awards to assist the large number of needy students in all four years of medical school.

Scholarship support provided through a set-aside from the Health Careers Opportunity Program (HCOP), the **Financial Assistance to Disadvantaged Health Professions Students (FADHPS)**, is also a much-needed source of financial aid to minority students with documented need. The FY 1991 appropriations for the HCOP program was $30 million and of that, only $3.6 million assisted approximately 1,500 medical students with average awards of $2,400 in 1989-90.

These two modest scholarship programs provide valuable and critical support for the most needy students who incur large educational debt. If Congress eliminates the

FADHPS programs, minority health professions students will be at a serious loss for federal scholarship assistance which, in turn, will continue to exacerbate the problems of the representation of minority and disadvantaged students in the health professions.

The **Health Professions Student Loan** (HPSL) is a campus-based revolving loan fund which provides students with low interest loans on the basis of need. In 1989-90, HPSL provided loans to 9,175 medical students. Although HPSL is designed to provide support for both educational expenses up to $2,500 plus the cost of tuition, in recent years loans have diminished to a point that the average loan now totals $3,502, while average tuition costs are approximately $12,500. The AAMC supports the Administration's proposed $15 million capital infusion to the HPSL program, and urges the Subcommittee to authorize "such sums as necessary" to promote continued growth in the program.

The AAMC recommends lifting the "exceptional financial need" requirement under HPSL for medical students. This requirement does not apply to any other health discipline. HPSL awards are made on a per capita basis. Thus, medical schools would not necessarily receive a greater share of HPSL allocations if the exceptional need requirement were lifted, but financial aid officers could offer relatively low-cost HPSL funds to a greater number of eligible medical students.

The **Health Education Assistance Loan (HEAL)** program provides a vital source of funding for medical students. Although it is sometimes referred to as the "loan of last resort," the availability of HEAL enables thousands of students to meet the costs of medical education, and thus, begin a career in medicine. In the 1989-90 academic year alone, approximately one-fifth of all medical students, a total of over 12,000 individuals, borrowed in excess of $100 million from the HEAL program. In this regard, the availability of HEAL plays an important role in assuring that the nation has an adequate supply of physicians. The AAMC urges Congress to reject the Administration's proposal to phase-out the HEAL program. The AAMC is aware of the need to minimize the number of claims and, thus, maintain the financial integrity of the Student Loan

Insurance Fund (SLIF). However, the Association does not support the Administration's proposal to replace the HEAL program with the HPSL program. The HPSL program supports loans to a limited number of all financially needy medical students, not to the broad cohort of students who borrow from HEAL. Eligibility for and resources available from HPSL would have to increase dramatically to support the needs of HEAL borrowers. Such action would jeopardize the success and continued integrity of the HPSL program. The AAMC believes the HPSL program should remain a program to provide subsidized, low-interest loans to very needy health professions students and that HEAL must be retained, with appropriate programmatic reforms, to ensure that all students can borrow the funds necessary to attend a health professions school.

The AAMC supports the concept of asking institutions, lenders, and secondary markets to meet certain standards for the purpose of alleviating the problems and expense associated with HEAL defaults. However, such accountability must be commensurate with each participant's role in the HEAL program. The responsibilities and initiatives necessary for an institution, lender, or secondary market to achieve compliance with an accountability standard must involve factors within the participant's sphere of influence and control and also in the context of the program's stated objectives. Therefore, in taking steps to correct the default problems in the HEAL program, the AAMC supports implementing a reasonable performance standard on medical schools participating in the HEAL program.

Moreover, the AAMC supports establishing a 12 percent cap on the HEAL interest rate to help curb the large expense students face with the HEAL loan. The interest rate is determined by adding three percent to the average bond equivalent rate of the 91-day Treasury Bill. In periods when the calculation exceeds an interest rate of 12 percent, the government would be responsible for providing the necessary subsidy to a lender so that the borrower would not be charged over the legal interest rate cap. Currently, the interest rate is 11 percent and the HEAL program has no legal cap on the interest rate. It is important to note that an established 12 percent interest rate will eliminate the potential for the rate to rise as high as 19 1/2 percent, as it did in the early 1980's. A limit on the HEAL interest rate will ease repayment and is likely to help reduce the number and cost of defaults.

Finally, the AAMC recommends repealing Section 729 (a) (2), which prohibits including HEAL in loan consolidation programs. Currently under the loan consolidation program, borrowers with a minimum of $5000 in student loan debt can refinance loans received from a variety of lenders participating in Stafford, SLS, Perkins, and HPSL student loan programs. Typically, the monthly payments are lower after consolidation than they would be in aggregate for borrowers with multiple loans, and, consequently, consolidation has the effect of reducing borrower defaults. The inclusion of HEAL in loans eligible for consolidation would greatly ease the payment burden for health professions borrowers with heavy student loan debt, and, thereby decrease federal loan default costs.

Minority Recruitment and Retention

Title VII plays an important role in the effort to increase the number of minority and disadvantaged students in medicine. The **Disadvantaged Assistance** program is the primary source of funding to assist in the recruitment and retention of minority students. The program, known as the Health Careers Opportunity Program (HCOP), provides grants to schools and other non-profit institutions to support the identification, recruitment, admission, retention, and placement of minority and disadvantaged students in the health professions. This support has helped participating medical schools establish and maintain a number of effective and creative recruitment and retention programs, including pre-matriculation courses, basic science enrichment courses, medical academic advancement programs, health careers information workshops, and academic assistance and tutorial programs. Together these initiatives have helped increase the applicant pool and reduce the attrition rate of minorities in medical school.

The Disadvantaged Assistance program is an essential component in national efforts to achieve a laudable and necessary goal, a goal to which the nation's medical schools and the federal government have been long and deeply committed. The AAMC recommends that the Disadvantaged Assistance program be extended and authorized for FY's 1992 through 1994, at levels of $35, $37, and $39 million.

The AAMC supports the **Excellence in Minority Health Centers** program which provides critical support to medical schools in their effort to increase minority representation in medicine. The percentage of Black, Hispanic, and Native American health professionals is still far below parity with their numbers in the general population. Federal efforts are necessary to help schools strengthen programs to enhance the academic performance of minority students attending school. These programs are used to train, recruit, and retain minority students and faculty, and contribute to improving activities in information resources and curricula development with respect to minority health issues.

The AAMC is committed to increasing minority representation in medical schools. In July, 1990, the Association initiated "Project 3,000 by 2,000" to achieve the longstanding goal of proportional representation in medical schools for students from underrepresented ethnic groups. The project goal is to increase the number of new first year minority students to 3,000 by the year 2,000, an increase of over 100 percent. The focus of AAMC efforts will be on early intervention in the education process. Specific projects will concentrate on expanded career options, educational enrichment, mentoring, and financial assistance. The AAMC will encourage academic medical centers to take the lead in organizing these efforts and work with others to promote minority youth success. Federal funding will be critical in enabling individual institutions to implement programs designed to achieve the AAMC's national goal.

Primary Care Training

Over the past five years, the number of graduates planning to be certified in primary care specialties has decreased from 30 to 23 percent. Approximately 2,000 communities in this country are still designated as Health Professions Shortage Areas (HPSAs) and 4,300 physicians are needed to provide primary care services in them. Moreover, 1990

National Resident Matching Program data indicates that only 55.7 percent of the available family practice residency positions were filled by graduates of U.S. medical schools. In general pediatrics, 55.6 percent of the available positions were filled by graduates from U.S. medical schools, and for general internal medicine the rate was 61.5 percent. Approximately 300 each of general internists and general pediatricians graduate annually from primary care track residency training programs. As more medical schools and teaching hospitals seek to increase their commitment to primary care education, model programs, as supported by Title VII grants, will be looked to for guidance in planning new educational approaches nationwide. The Title VII primary care grant programs are a valuable and necessary source of funding for the development and continued existence of primary care educational programs for many medical schools and teaching hospitals.

Federal funds have been crucial in the development of many **Family Medicine Departments** and **Family Medicine Residency and Training** programs. In the 1980's, federal funding partially supported about 40 percent of the family practice programs which train about 50 percent of the graduates. Currently there are 100 medical school departments of family medicine providing ambulatory based training to prepare residents and medical students for ambulatory based practice to encourage graduates to practice in rural and other underserved areas. The family medicine departments, as a result of the nature of their training facilities, are often faced with difficult financial constraints. Over two-thirds of the residency programs are located in community hospitals, rather than traditional tertiary medical centers. In addition to the community hospitals, family practice residency programs are affiliated with community health centers, migrant health centers and free clinics. Location in non-traditional training sites, coupled with an ambulatory based training model, presents the residency programs and departments with serious financial challenges. Patient revenues have not been able to provide support for major family medicine programs. Furthermore, the presence of an education mission in family medicine clinics decreases the productivity of such clinics. As a consequence, primary care residency programs depend heavily on federal support. Enhanced targeted federal support is essential for these programs to support the goal of increasing the number of primary care physicians. The AAMC recommends "such sums as necessary" for these programs to encourage continued growth.

The **General Internal Medicine and General Pediatrics Residency** programs have been very effective in increasing the number of general internists and general pediatricians. These residency programs have been heavily involved in the process of primary care education because of the programs well-defined, closely monitored, continually evaluated curricula and a strong administrative structure. These federally-funded primary care training programs provide physicians greater exposure to continuity of care settings, more comprehensiveness in clinical rotations, greater diversity in community-based training sites, and training in geriatrics education. It is these characteristics that enhance the quality of training in primary care and increase the number of physicians entering the field because the of the documented positive educational and professional experience. The AAMC recommends that the Title VII reauthorization legislation include language establishing pre-doctoral clerkships for general internal medicine and pediatric programs. Such predoctoral programs are already authorized for family practice under the current legislation and have proven quite successful. The AAMC recommends for FY's 1992 through 1994, total authorization levels of $27, $31 and $36 million for the existing programs, assuming in successive years the proposed $2, $3, and $4 million will be allocated to pre-doctoral clerkships.

Geographic Maldistribution

The **Area Health Education Centers (AHECs)** program supports the dispersion of primary care physicians and other health care professionals into medically designated shortage areas by providing incentives for students through training opportunities and practical experience in geographically remote areas away from the main campus. Currently 38 AHEC programs exist nationwide, constituting a national resource for dissemination of federal priorities and new technologies to health professionals in clinical settings. The AHEC program has been successful in linking the resources of university health science centers with the health care and educational needs of communities. The AHEC program was established as one of three parts of a vital triad created to help solve the nation's health care delivery crisis. The Community and Migrant Health Centers assured the delivery of health services to medically underserved areas, the National Health Service Corps assured a supply of health professionals to staff those centers, and the AHEC program assured the support of the health professional schools in the recruitment and retention of providers who would work in medically underserved areas. The same health care issues that plagued the nation in the 1970's are as important today. The AHEC program is a crucial component of health care delivery in our country. The AAMC recommends reauthorization for FY's 1992 through 1994 of $23, $25, and $27 million.

Health Education Training Centers (HETCs) improve the supply, distribution, and quality of health care services along the border of Mexico and the United States, and in other severely medically underserved areas. Emphasis on health promotion and disease prevention through public education should continue to be emphasized through the HETC program. For FYs 1992 through 1994, the AAMC recommends reauthorization levels of $8, $12 and $16 million.

Geriatric Training and Faculty Development enables physicians to be trained in geriatric medicine. The grants support medical schools, teaching hospitals, and graduate medical education programs for academicians and researchers. Funding provided for curricula development and patient care delivery systems are essential to accommodate the increasing health care needs of America's aging population. The AAMC supports geriatric training and faculty development and the appropriate role they play in encouraging the focus of medical educators in gerontology and geriatric medicine. To support these goals, the AAMC recommends reauthorization levels of $5, $5.5, and $6 million, for FYs 1992 through 1994.

Geriatric Education Centers (GECs) provide short term faculty training, curriculum and other educational resource development, technical assistance, and outreach. The programs continue to emphasize multidisciplinary education and are affiliated with other educational institutions, chronic and acute care hospitals, community-based centers for the elderly, ambulatory care centers, nursing homes and VA hospitals. Many centers include geriatric evaluation units that function as centers for clinical training. These also serve both continuing education and clinical rotation functions for training health professions students. The AAMC recommends reauthorization levels of $16, $19, and $22 million for FYs 1992 through 1994.

Special Projects

Preventive Medicine Residency programs provide funding for the development of new residency training programs and assist residents in preventive medicine training programs through financial aid awards. In addition, the Special Projects Section 788 provides funding for a number of important model education projects for health professions training in this field of growing concern. For FYs 1992 through 1994, the AAMC recommends reauthorization levels of $5, $5.5, and $6 million for these programs.

Rural Health

Grants under section 799A provide interdisciplinary training for health professionals to provide services in rural areas. These rural health initiatives help promote and encourage medical students to elect the critical career choice of practicing in underserved, rural areas. The AAMC recommends reauthorization levels of $5, $5.5, and $6 million for FYs 1992 through 1994.

Summary

Title VII represents a successful partnership between the federal government and the nation's medical schools and teaching hospitals which continues to have beneficial results for the health of the American people. It is clear that federal support should continue to be targeted to student assistance, minority recruitment, and expanded primary care training opportunities in conjunction with other programs designed to help solve our nation's geographic and specialty maldistribution problems. Title VII is a relatively small set of programs, but its influence on access to high quality education has been crucial to the continuing excellence of the U.S. health care delivery system. The AAMC supports reauthorization of the key programs mentioned above and appreciates the opportunity to participate in the debate of developing effective policies to ensure the availability of well trained physicians and appropriate modalities of health care in our nation.

Testimony of

David Satcher, M.D., Ph.D.
President

THE ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

Mr. Chairman and members of the Subcommittee, thank you for the opportunity to present the views of the Association of Minority Health Professions Schools regarding the reauthorization of the Health Professions Training Assistance Act.

Our Association is comprised of 8 historically black health professions schools; the Meharry Medical and Dental Colleges, in Nashville, TN; the Charles R. Drew University of Medicine and Science in Los Angeles, CA; the Morehouse School of Medicine in Atlanta, GA; the Florida A&M University College of Pharmacy in Tallahassee, FL; the Texas Southern University College of Pharmacy and Health Sciences in Houston, TX; the Xavier University of Louisiana College of Pharmacy in New Orleans, LA; and the Tuskegee University School of Veterinary Medicine in Tuskegee, AL. These institutions have trained 40% of the nation's Black physicians, 40% of the nation's Black dentists, 50% of the nation's Black pharmacists, and 75% of the nation's Black veterinarians. Most of these graduates are working in the nation's underserved rural and inner city communities.

Mr. Chairman, we are very proud of the accomplishments of our institutions, especially given the significant challenges that we have overcome throughout our existence. Our schools are considered by many to be a national resources. Only recently has the federal commitment to supporting these institutions and the students who attend our schools become a significant issue.

Shortages of Minorities in the Health Professions:

The gains made in black enrollment and graduates in health professions education programs peaked in the mid-seventies. The deteriorating pool of minority applicants to medical schools, the growing debt burden of minority students pursuing health careers and the persistent shortage of minority faculty in medical schools were all cited by the Council on Graduate Medical Education as major factors contributing to the deteriorating state of minority representation in medicine.

According to the COGME report the problem of recruiting minority students to medical school is directly linked to poor early academic preparation and insufficient encouragement. There is a high dropout rate among minority students and evidence that those who remain in the educational pipeline are often inadequately prepared for study in the health sciences.

The report also noted that minority students incur higher debt levels than majority students, and are being more severely impacted by rising tuition costs and the decreasing availability of scholarships and other desirable forms of financial aid. If this situation continues it will exacerbate the decline in minority applicants to medical school and will further discourage minority students from choosing to practice in primary care specialties and in underserved areas.

Finally, the report noted that minorities are severely underrepresented on the faculties of U.S. medical schools and the this underrepresentation has a negative effect on both the recruitment, enrollment, and graduation of minority students and the professional development of all medical students.

The attrition rate of minorities in health professions schools has also been identified as a major problem. Comparatively, the retention rate of minorities is much lower than that of non-minorities. It is clear that it is very important to keep these students enrolled once they are in school, given the already significant investment made in nurturing these students.

For a long time our schools have struggled against terrific odds to survive. The support of your subcommittee in terms of federal resources for programs impacting our students and our institutions has had and will continue to have a significant impact in enabling us to achieve our mission - to improve the poor health status of Blacks and other minorities and to address the underrepresentation of blacks and other minorities in the health professions.

Mr. Chairman, despite the recent federal support that has been provided to our institutions, there is a historic shortage of minorities in the health professions While Blacks represent approximately 12% of the U.S. population, only 2-3% of the nation's physicians, dentists, pharmacists, and veterinarians are Black. Studies have demonstrated that when blacks are trained in the health professions, they are much more likely to serve in medically underserved areas, more likely to take care of other minorities and more likely to accept patients who are Medicaid recipients or otherwise poor. For this reason, it is imperative that the federal commitment to training blacks in the health professions be strong. It is also important to note that our institutions endure a financial struggle which is inherent in our mission to train disadvantaged individuals to serve in underserved areas. Because of the financial plight of our students, our institutions are not able to use tuition to respond to the discontinuation of capitation or other forms of federal support for health professional education. In addition, because the patient populations served by these institutions have been historically poor, they have not earned money from the process of patient care at a time when the average medical school gets 40 to 50% of its revenue from patient care.

Poor Health Status of Blacks

There is a direct correlation between the underrepresentation of minorities in the health professions and the health status disparity among Blacks and Whites. The 1985 HHS Secretary's Task

Force Report on Black and Minority Health documented that the infant mortality rate for Blacks is almost double that of Whites, and that life expectancy for Blacks is significantly shorter than that for whites. Blacks suffer disproportionately high rates of cancer, diabetes, pulmonary complications, and other disorders that contribute to 60,000 annual excess deaths per year among blacks when compared to whites. If not for the efforts of historically black health professions schools, the health status disparity between minorities and the general population would be even greater.

Unfortunately since this historic report the health status disparity between the two groups has actually worsened. Black life expectancy has decreased and AIDS, which was not even mentioned in the 1985 report is now a leading cause of death and disproportionately affects blacks and other minorities - minorities who constitute 24% of the population but 45% of the AIDS victims.

Reauthorization of Health Professions Initiatives

AMHPS is very supportive of the continued existence of the various programs in the Health Professions Training Assistance Act. Please allow me, Mr. Chairman, to express the appreciation of our Association for the action your subcommittee took last year to approve the Disadvantaged Minority Health Improvement Act. That initiative included many programs to aid minority health - including an expansion of the Centers for Excellence program and new authority for Health Professions Loans, a Disadvantaged Minority Scholarship program, Health Services for residents of public housing, and statutory establishment of the Office of Minority Health.

We are concerned that there may be a growing sentiment to trade the support for current health professions programs for the minority health initiatives. This would be inappropriate. The minority health initiative is a distinct and critical thrust which is not intended to replace support for traditional health professions training programs.

Exceptional Financial Need

EFN resources are among the most critical in our institutions' ability to offer a bright student a promising educational opportunity. Although Congress has allowed for greater flexibility in the distribution of funds so that EFN funds are eligible for more students, the authorization levels have not been increased accordingly. We believe that the authorization level must be increased to allow for continued support to the increased number of students eligible for these scholarships.

Disadvantaged Assistance (H-COP)

The Health Careers Opportunity Program (H-COP) is a valuable resource in our ability to identify, recruit, retain and train minority health professionals. It is the primary health preparation program for underrepresented minorities entering the health professions. These programs have gone a long way toward maintaining or increasing minority enrollment in many health professions schools. These contracts and grants are very important to our school's ability to attract disadvantaged students into the health professions. We firmly believe that the committee should carefully look at the original intent of the legislation to support select programs that contribute significantly to training disadvantaged minority individuals. Currently we believe the program funding is spread too thinly among too many institutions to have the type of impact that was anticipated.

Health Professions Student Loans & Health Education Assistance Loans

We are concerned that HPSL loans will be viewed primarily as a replacement and not as supplement to HEAL loans. HPSL funds will be used to assist minority institutions develop and maintain a sufficient revolving fund as many minority institutions have not had sufficient time or resources to develop revolving funds.

The HPSL program is insufficient to replace the intended function of HEAL loans. HEAL loans are an important component of the overall health professions authority, yet they often carry a prohibitive interest rate that discourages an individual, especially a poor minority, from seeking a health professions career. AMHPS recommends that there be no limit placed on these loans and that compounding of interest is reduced in order to lower repayment amounts. Minority students incur a higher debt than majority students and consequently would be disproportionately affected by a phaseout of this program.

Area Health Education Centers Program

The AHEC program is designed to increase the number of health practitioners in shortage areas by awarding funds to medical schools that provide training at remote sites that are designated health manpower shortage areas. Our Association adamantly opposes the elimination of this important program and in fact supports an expansion of this important initiative.

Special Education Initiatives

We believe that the Health Professions Special Education Initiative, which supports two year medical schools, such as the Charles R. Drew University of Medicine and Science, is an extremely important priority. The support for the development and enhancement of basic science or clinical medical educational efforts aids two year schools which are improving their medical curriculum and making preparations to become 4 year schools.

Mr. Chairman, thank you for the opportunity to appear before your committee. We deeply appreciate the support you have demonstrated in the past for training minorities in the health professions, and pledge our support for the reauthorization bill.

ASSOCIATION OF PROFESSORS OF MEDICINE
and the
ASSOCIATION OF PROGRAM DIRECTORS IN INTERNAL MEDICINE

Mr. Chairman and Members of the Subcommittee:

The Association of Professors of Medicine (APM) and the Association of Program Directors in Internal Medicine (APDIM) are pleased to have the opportunity to submit testimony on the health professions training programs of funded under Title VII of the Public Health Service Act.

The APM represents the chairs of departments of medicine at the 126 American medical schools. One of the capacities in which APM members serve is as directors and overall supervisors of the internal medicine residency training programs in academic medical center and major university teaching hospitals. In this role as teachers to young physicians, APM members and their faculty provide training during the standard three years of the residency program in general internal medicine. That is, residents are given a broad exposure to a variety of system-related conditions, both on the ambulatory and in-patient basis, the care of intensively ill patients, instruction in numerous procedures used in practice, the management of patients on an continuity basis, and other cognitive and procedural skills necessary for the practice of internal medicine.

The APDIM is a national service organization representing over 1000 individuals responsible for the training and education of all internal medicine residents at accredited residency programs, including university, community, municipal, and VA medical center hospitals throughout the United States and Puerto Rico. Program directors and their staff interact with over 19,000 internal medicine residents on daily basis and facilitate meeting the primary health care needs at both urban and rural sites throughout the United States.

Data clearly indicate the societal need for more general internists. At the same time, however, there has been a decline in interest in internal medicine and other primary care careers among graduating students. The reasons behind this decline are varied, but two appear to play a large role in the eyes of the APM and APDIM: First, the generally high levels of debt incurred by medical students and the relatively low (compared to other specialties) compensation received by general internists early in their careers. While there is no hard evidence to support this belief, a large body of anecdotal evidence points to it having a large impact on the career decisions of young physicians. [The APM plans to explore possibility of an in-depth study of the impact of medical student debt on the choice of internal medicine as a career.] Second, high demands to provide patient care services are placed upon residents in most major teaching hospitals, in large part due to the high acuity of illness of the patients admitted to these hospitals. This situation makes the residency itself a demanding undertaking, compared to other fields. As student's concerns over "lifestyle" during residency apparently increase, this situation becomes more of a factor. In addition, the need for all physician services, both resident and faculty, to cover the in-patient population, makes development of a generalist curriculum more difficult.

A fairly large number of internal medicine residency training programs use the so-called "tracking" model for their training programs, where early on in their residency trainees choose a curriculum that will orient them towards training either in primary care general internal medicine or towards one of the medical subspecialties (nephrology, cardiology, gastroenterology, infectious diseases, etc.). The aim of the primary care tracks is to design teaching modalities and sites where training can flourish that will prepare these physicians to care for a wide variety of patients on a continuous basis.

Since their inception in the 1970s, many medical school departments of medicine have received a grant under section 784 of Title VII. Of the 55 grants currently being funded under the combined general internal medicine/pediatrics program, 29 have been awarded to departments of medicine. These funds are invaluable to the operations of general internal medicine programs, because, one they place training funds directly into the hands of the chairmen or program directors, unlike different sources of graduate medical education support that are filtered through other parts of the academic medical enterprise.

In addition, these grants are also useful because of their dual purpose; funds awarded under Section 784 can be used for both residency training as well as faculty development. This is particularly important because the development of faculty dedicated to teaching general internal medicine is one of the keys to increasing the numbers of students entering general internal medicine, because of the proven influence of positive faculty role models. Clinical skills are valued very highly for instructors of this type, and they must necessarily be nurtured along a different path than more traditional, subspecialty based faculty. Title VII funds help compensate departments for lower amount of patient care revenues produced by generalist faculty, as well as the additional dollars lost due to time spent teaching. It would be difficult in many cases for departments of medicine to support the same number of primary care faculty in the absence of the Title VII funds.

It should also be noted that general internists and other primary care physicians provide the majority of the medical care services to undeserved populations, both in the inner-cities and in rural America. Still, there are not enough of these types of physicians to care for the undeserved as well as provide for the needs of the general population. As the APM and APDIM have submitted that Title VII funds aid in the training of increased numbers of general internists, the need for these physicians by the least fortunate in our society is reason enough for their continuance.

The APM, APDIM and the other major primary care organizations, supported testimony recently presented before the subcommittee by Robert Graham, M.D. of the American Academy of Family Physicians. The testimony draws attention to the Bush Administration's proposed elimination of funding for the general internal medicine/pediatrics and other health professions training programs funded by Title VII. We strongly opposes this discontinuance; we believe that this could lead to the closure of a number of primary care residencies or, at the very least, a reduction in the number of primary residency positions.

Overall, the APM and APDIM recommend the following levels be authorized in the Subcommittee's bill for section 784 of Title VII: $27 million in FY 1992, $31 million in FY 1993, and $36 million in FY 1994. Both Associations believe that this increase is justified by the identified need for increased numbers of primary care physicians.

The joint testimony also urges that funds authorized under Section 784 be made available for pre-doctoral training in general internal medicine and pediatrics. Interviews with medical residents and students and other data sources show a clear connection between exposure to primary care at an early level and career choice. In fact, studies have consistently shown that positive experience during the clinical clerkships -- the period, usually during a medical student's third year, when they spend a specified period of time working in clinical medical specialties, such as internal medicine, surgery, psychiatry, pediatrics, etc -- plays a great role in their selection of a residency. Therefore, the we support the addition of $2 million in FY 1992, $3 million in FY 1993, and $4 million in FY 1994 for pre-doctoral training under section 784.

The APM and APDIM would also like to express their strong opposition to legislation, H.R. 2231 "The Primary Care Training Amendments of 1991", introduced recently by Rep. Jim Cooper. This legislation would mandate that in order to be eligible to receive a Title VII grant, a medical or osteopathic school must have both a department of family medicine, as well as required clerkship in family medicine during the students' third year. Our reasons for opposition are two-fold. First, it is highly inappropriate, and without precedent, for the federal government to micromanage medical school curriculum in this type of manner. The mission of each of the 126 medical schools, while having the common purpose of training high quality physicians, is in someway different especially among those with a strong commitment to, and investment in, biomedical research; it would be a mistake and bad public policy to mandate that these institutions develop family medicine departments from scratch.

Second, should institutions be forced to develop departments and clerkships in family medicine, the funds used to establish these units would be taken from the very training programs Title VII funds now help support and the trainees to which they are dedicated. The overall financial situation in academic medicine is not particularly good; funds would have to be taken from existing programs -- such as internal medicine and pediatrics -- in order to establish the new family medicine training efforts. The end result would most likely be that fewer overall primary care physicians would be trained through compliance with this federal prescription.

Rep. Cooper's legislation is also flawed in that it equates only family medicine with primary care; **in fact, general internists care for more patients in all illness and income categories than do their family medicine colleagues**. The APM and APDIM believe that the general internist is also trained in a manner that provides him the best training and clinical skills necessary to care for the majority of patients needing medical care.

The APM and APDIM also wants to mention the Administration's proposed elimination of the Health Education Assistance Loan (HEAL) program. There are serious, and legitimate, concerns raised about the level of debt that a medical student can incur under loans from this program. As mentioned earlier, the APM believes that indebtedness has a major impact on why fewer students are choosing careers in internal medicine and other primary care careers. We support measures aimed at loan forgiveness as an incentive to enter primary care fields, such as the National Health Service Corps. Nevertheless, we oppose the elimination of the HEAL program in the absence of another federally-guaranteed program for general financing medical student education.

In conclusion, the we urge the subcommittee to reject the Administration's planned cut-off of funding for section 784 and other training programs funded by Title VII. These funds are very important to efforts at training more primary care physicians needed by millions of Americans. We would be happy to provide the Subcommittee with any additional information it wishes.

Statement of the Association of Schools and Colleges of Optometry

OPTOMETRIC EDUCATION: VISION FOR THE FUTURE

THE CHANGING WORLD

Vision is our most precious sense. It is the primary means by which we acquire knowledge and perceive the world. Most citizens of the United States who seek to protect, preserve, and enhance their vision do so through the services of optometrists. Optometrists also serve as a primary entry point into the health care system through the diagnosis of ocular conditions which indicate such diseases as diabetes, hypertension, and other systemic abnormalities which are often first revealed by ocular symptoms.

The "graying of America" has substantially increased the demand for vision care and rehabilitation. At the same time, there is an increasing need to improve the learning skills and educational capabilities of our children to be competitive in a technological world. Both geriatric and pediatric vision care have always been important traditional aspects of optometric service.

Of striking consequence is the change in the scope of optometry during recent years, from a profession initially accountable for facility of visual function - such as improving visual acuity, and providing coordinated, clear vision - to additional responsibility for the integrity of the ocular structures such as dealing with pathological conditions of, and injuries to, the eye. The need to enhance and develop existing and new curricula as well as applicable clinical and residency exposures for increased training has placed an extended burden upon optometric education.

Computerization and related electronic innovation have markedly altered the technology and instrumentation for examination of the eye and diagnosis of ocular diseases. These developments have not only improved reliability but also expedited examination procedures. The acquisition and integration of this expensive equipment into the didactic and clinical phases of optometric education has presented a major challenge.

A number of highly original research techniques are in process which have tremendous diagnostic and prognostic importance. These techniques have the potential for indicating abnormal conditions far in advance of present day procedures. There is a critical need to integrate these procedures, and accompanying critical instrumentation, into the customary routine of vision care.

THEN AND NOW

In the 1960s, the Health Professions Educational Assistance Act (HPEAA) provided construction funds to the existing schools and colleges of optometry. In 1964, optometry students became eligible for scholarships and loans under this Act. In 1971 the Comprehensive Health Manpower Act, which replaced the HPEAA, included capitation grants, basic improvement grants, (a continuation of provisions of the HPEAA) and special project grants. However, institutions established since 1971 have received only minimal support from this and succeeding legislation. Since 1979, federal assistance to optometric education institutions has been limited to student loans and scholarships. During this time, no support has been received through capitation grants, basic improvement grants, or special project grants.

Congress is to be commended for its recognition of the promise of optometric education and service and for its past support. However, the Comprehensive Health Manpower Act of 1971, and succeeding legislation, have not met the urgent needs of the present. Reaffirmation of federal support is needed to continue the positive effect of the achievements in optometry. These achievements apply significantly to:

- early recognition of major systemic disorders through ocular symptoms
- devices to improve low vision resulting from the debility of aging
- rehabilitation of visually handicapped children
- improvement of learning skills and anticipated improvement of the United States' competitive edge in a world of increasing technology
- improvement in industrial production resulting from sharper vision, and a visually enhanced environment
- general enrichment of the quality of life

Funding limitations may not only inhibit the realization of these achievements, but also restrict future research and development. Another result could be to discourage the entry of promising young people into the field of optometry.

These issues are national in scope. Visual and ocular anomalies affect most of our population and include members of our families, our friends, and our neighbors. Among our most significant losses are those who are unable to realize their innate potentials because visual impairments limit their powers and their consequent contributions to society.

OPTOMETRIC AND DENTAL EDUCATION: SIMILARITIES

In order to provide a basis for comparison, it should be pointed out that the funding needs of optometry schools are essentially the same as those of dental schools. This conclusion is based on the following similarities:

- Both involve four academic years plus clerkships, internships or externships.
- Both require the same period of undergraduate collegiate education.
- Both devote approximately half of the curriculum to basic and clinical sciences and half to clinical training as well as some didactic courses involving professioinal practice.
- Both are expected to be productive in basic and clinical research.
- Both produce independent practitioners who are primary health care providers.
- Both provide unique services in a specialized area, but one in which a majority of the population require care.

RESTORING THE COMMITMENT

This statement has been prepared by the Association of Schools and Colleges of Optometry which represents the seventeen schools and colleges of optometry in the United States. Its purpose is to describe to Congress the needs of optometric education. On behalf of the millions of Americans who depend upon the optometric profession for the attainment and preservation of clear, comfortable vision and eye health, Congress is asked to consider the recommendations in this document as a first step towards renewing its commitment to the promise of enhanced eye care.

Optometric education in the United States is, without question, the best in the world. A considerable reinvestment in the infrastructure of optometric education by the federal government will preserve and expand this status. Congress must renew its investment in the critically required facilities, services, personnel, and research support. A survey of all seventeen U.S. optometry schools, conducted in May of 1990, indicates that the following areas demand immediate attention:

I. CONSTRUCTION AND RENOVATION OF PHYSICAL FACILITIES

Those institutions which derived funds for constuction in the years 1960 - 1970 now face the urgent need to refurbish the normal debilities of time and wear. Many of the seven schools established since 1971 have received no federal support for construction or renovation. In addition, over the same period, the changes in the scope of practice of optometry have necessitated introduction of new facilities and/or redistribution of the space available in even the best conditioned buildings.

II. CLINICAL DEVELOPMENT

The replacement and introduction of specific clinical equipment is a primary concern. There is a need for ongoing refurbishing of examining instruments and equipment, which suffer extraordinary stress through constant use by students and interns. This need also includes the continued updating of automated and computerized devices which enhance methodology by both improved reliability and expedited procedures. Unfortunately, these devices are extraordinarily expensive. A further necessity is the technical development for clinical applications of special "imaging" laboratory processes.

These methods have the potential to reveal conditions at very early stages, well in advance of most presently used diagnostic procedures. Finally, expansion of clincial facilities is essential to increase patient access to the "state of the art" of present day optometry.

III. CURRICULUM DEVELOPMENT

Optometric curricula: particularly pharmacology, pathology, immunology, and related biomedical fields are experiencing a needs explosion for space, for new equipment, and particularly, for additional specialized members of the faculty. Continuing curriculum development in these and other areas of optometric education is vital to the ongoing enhancement of optometry's role as provider of the diagnosis, treatment and management of ocular disease. Augmented clinical training is also required to accompany an expanding didactic educational experience.

The ability to constantly "renew" existing faculty is crucial to optometric education so that they may keep abreast of advancements in instrument and computer technology, methodologies, and research functions. Residency education involving post graduate clinical specialization has grown in the last fifteen years, and has become a significant new source of clinical education in optometry. It is now apparent that residency education must be further expanded and better coordinated into the teaching programs.

IV. REHABILITATION OF VISION

While rehabilitative optometry includes a number of aspects, major emphasis is placed here upon three: geriatrics, low vision, and pediatrics. The graying of America has introduced a genuine problem of the specialized visual needs of the geriatric population. The Association of Schools and Colleges of Optometry, through a federally supported grant, has already initiated a curriculum in geriatrics and has developed a gerontology manual. However, development of the geriatric curriculum is still needed.

Present indications are that reduction and loss of vision is a normal accompaniment of advancing years. An increase in the number of individuals bound to suffer from low vision can be readily anticipated. The development of both devices and procedures for augmenting available vision and appropriate training in vision rehabilitation is essential.

The development of pediatric optometry indicates the profession's concern with correcting poor vision in children, which may also play a major role in reducing adult illiteracy. The public concern with the effect of illiteracy upon individual lifestyle, contributions to society, and international industrial competition has long been recognized by optometry. Research in the relationships between visual defects and illiteracy and the potentials for correction needs to be greatly expanded.

V. RESEARCH

The importance of research to any scientific field is evident. In optometry, clinical research requires development and expansion particularly in, although not confined to, the areas reflecting the broadening scope of practice. Research is also greatly needed in the further generation of state-of-the-art technology. Equally critical is the amplification of the imaging techniques and technical development of the instrumentation applicable to clinical use.

Continued research in existing environmental and industrial studies will help to identify and create proper indicies of lighting and colors, thereby increasing safety and efficiency. Studies measuring the relationship of visual aptitudes to all types of human performance and the impact of specialized training on accomplishment are also increasingly important. Clincial research requires support in facilities, specialized equipment, trained faculty, support personnel, and graduate student participation. Educational research to assist in developing improved strategies in teaching and learning within the optometric profession are also critically needed.

VI. MINORITIES

Support is needed for recruitment of minority students into the profession of optometry and for retention of such students to graduation. Some success has already been achieved by virtue of summer enhancement programs and making tutorial programs more available. Additional programs for this purpose must be developed and instituted. Equally important is the need to provide adequate financial support to minority students, particularly those who are often financially disadvantaged and thus, most burdened by the rising cost of optometric education.

In addition, funds to recruit and retain faculty and to assist eligible students in graduate programs leading to faculty positions are essential in order to establish appropriate role models in teaching, research, and administration.

VII. STUDENT FINANCIAL ASSISTANCE

Eighty six percent of optometry graduates in 1990 required federal financial assistance. In spite of the fact that the average amount of indebtedness continues to escalate, in some cases as high as $80,000, and the costs of establishing a practice are considerable, the repayment record of optometry graduates is the best of all the health professions. In order to keep these debts at manageable levels, it is imperative that optometry students continue to fully participate in all federal financial assistance programs and that they have access to scholarship funds and loans at affordable rates.

NEEDS AND OPPORTUNITIES

The needs of optometric education are compelling. There has been no major infusion of federal funds for optometric education in many years. This situation has led to a potential shortage of equipment and deterioration of physical plants. A major challenge is the development of curricula required to keep pace with the rapid advancements occurring in eye and vision care. This development involves physical and clinical facilities, equipment, numbers of faculty, and faculty preparation and training. In the national interest, there is an immediate need to fund innovative educational programs required to meet the growing eye care needs of the American people.

ASSOCIATION OF UNIVERSITY PROGRAMS IN HEALTH ADMINISTRATION

Mr. Chairman and members of the subcommittee-

My name is Gary Filerman and I am President of the Association of University Programs in Health Administration, a consortium that includes 53 U.S. graduate schools with a network of collaborating health services foundations, business organizations, and government agencies. Our primary mission since the time the Association was founded back in 1948 has been to focus the resources of higher education on a single goal: managing health services with optimum quality, efficiency, and responsiveness.

Mr. Chairman, perhaps the most critical challenge confronting our health care system today is the coordination and management of a system that will cost-effectively serve the health needs of all citizens. And never has that challenge been so great.

For in spite of more than a decade of intensive efforts to curb health care costs, medical spending by Americans continues to grow faster than the rate of inflation. At the same time, we are seeing an explosion of new types of health care organizations--such as HMOs, PPOs, and home health agencies--that emphasize prevention, primary care, and low-cost alternatives to traditional health care systems.

Unfortunately, many of the efforts that have been undertaken to control rising costs and find more cost-effective methods for meeting America's health service needs have met with only limited success.

Why? In large part because these efforts outrun the management capabilities of the very system they are intended to help.

The fact is that nearly every aspect of health care policy--from assessing expensive new technologies to AIDS patient management to dealing with nursing shortages--is ultimately the responsibility of health services administrators. Administrators must create the conditions under which physicians, nurses, and other health professionals are most productive by drawing together the needed resources, while making sure that quality and cost control systems function properly.

Whether or not they are up to the task will in large measure determine the success or failure of new federal policies where it counts--in the community.

The sad fact is that management competence in health services is grossly uneven.

As critical as these positions are to our health care system, we know that as many as two-thirds of the nation's health services administrators lack the professional management skills needed to deliver quality health services on an equitable and cost-effective basis. And while some may argue that there is an oversupply of health professionals, quite the opposite is true when it comes to health services administrators.

There are in fact extremely serious management shortages in HMOs, emergency medical systems, nursing homes, home health agencies, community health centers, and rural hospitals. In fact, while the Department of Health and Human Services seeks to terminate funding for Health Administration, another arm of the government--the U.S. Department of Labor--has designated health services administration as the area with the largest unmet need of the decade.

From a practical standpoint, what does all this mean?

It means that whatever steps you and your colleagues here in Congress take to contain costs or improve services will be limited by managers' inability to effectively implement federal policies.

It means that physicians and other health professionals will not be fully productive because the settings in which they practice will not be properly managed.

It means that any efforts you in Congress make to achieve equity in rural or inner-city health facilities will be hampered, thereby discouraging practitioners who might otherwise be motivated to serve there.

RECOMMENDATION

To help avoid those problems and ensure a supply of adequately trained health administrators,Mr. Chairman, I am here today to urge the subcommittee to extend and expand the authorizations for two Title VII programs: $3 million for Health Administration Grants currently authorized under section 791 and $1.5 million for Health Administration Traineeships authorized under section 791A.

I realize that such comparatively small sums of money are easily brushed aside or overlooked. Some are inclined to think that programs that are this small cannot possibly have any real impact.

Quite to the contrary, Mr. Chairman.

Both programs have a proven track record of success. Furthermore, both serve to leverage a substantial investment of matching funds from universities and other sources. Each year, in fact, the federal dollars Congress has appropriated have attracted resources well beyond the statutory matching requirements--often as much as $8 in private funds for every federal dollar.

But most importantly, Mr. Chairman, these modest programs represent one of the very few direct line investments the federal government makes to help strengthen the management of our health care system. And without appropriate management competence, no enterprise as large or as important as this country's health care system can operate effectively.

EDWARD R. ROYBAL, CA
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STATEMENT OF EDWARD R. ROYBAL
CHAIRMAN, HOUSE SELECT COMMITTEE ON AGING

for the
Health and Environment Subcommittee of the
House Energy and Commerce Committee
hearing on May 30, 1991

Mr. Chairman and Members of the Committee:

Thank you for holding this hearing today. As you well know, I am very concerned with the allied health professional shortage we are currently facing. It frightens me to think that while I and many of our colleagues are fighting for comprehensive health care reform for the millions of uninsured and underinsured Americans, we do not have adequate numbers of health professionals to care for them. Not only are we faced with a shortage, we also must improve the quality of education and training that our health professionals today are receiving. One of the results from a hearing held by the House Select Committee on Aging, which I chaired, showed that many practicing professionals lack adequate training.

I along with my colleague, Representative Bruce have introduced the **"Allied Health Professionals Promotion Act of 1991" (H.R. 1466)**. This legislation was promulgated by the findings discussed at the March 4, 1991, hearing, "Long Term Care Personnel: Incentives for Training and Career Development". This hearing revealed several problems. First, no federal funding programs were authorized to support allied health education during the period of 1981 to 1989. Public Law 100-607, the Health Professions Reauthorization Act of 1988, authorized $6 million, but only $737,000 was appropriated for grants and contracts. For Fiscal year 1991, $1,659,000, was appropriated for grants and contracts. That money will only make it possible to provide continuation support for seven grants and perhaps fund ten new projects.

Another issue we addressed at the hearing was the effort to incorporate elder care into the allied health curriculum. Unfortunately, recent attempts to include elder care into these curriculums have been inadequate and personnel shortages will persist and worsen unless we take action now. A startling fact which illustrates the gross shortages we are facing was reported by the Institute on Medicine (IOM). The IOM report, "Allied Health Services: Avoiding Crises," found that the ratio of FTE physical therapists to registered nurses is 1:2 in rehabilitation hospitals compared with 1:43 in acute care hospitals. We cannot provide access, nor quality care to the 34 million uninsured and underinsured Americans, much less strive to provide quality health care for all Americans if we lack the allied health professionals.

The final point I want to address which resulted from the March 4, hearing, is the curricular reform barrier the shortage is creating. The IOM study concluded that improved education in geriatric care would: 1) aid in the retention of existing practitioners; 2) illuminate the rewards of a geriatric career for students and augment recruitment; and 3) encourage faculty to engage in geriatric service and clinical research relevant to long term care. I refer to this study because it emphasizes the need to move forward with an initiative that addresses the allied health personnel shortage. It is a shortage which we must address in the 102nd Congress. We are hearing more and more about health care for all Americans and allied health professionals are a necesssary component of any kind of health care reform.

H.R. 1466 addresses the problem of the lack of allied health professionals and insufficient education and training. This bill which I introduced with Mr. Bruce establishes four objectives: 1) provide project grants to those allied health fields determined by the Secretary to be in short supply; 2) provide allied health student traineeships; 3) provide advanced training of allied health personnel; and 4) authorize the establishment within the Health Resources and Services Administration an Advisory council on Allied Health. Our goal is to provide $96 million total funding for this initiative by the fiscal year 1994.

We cannot allow these problems to persist. Procrastination and denial that there is a problem in the area of the allied health professions will only contribute to the growing problem. If we are to implement a national health care system that will provide access to all Americans, we must build a quality system that works, not a system where the health care demand exceeds the provider supply. It must be a system that works because it means quality and access for all Americans.

Again, I thank you for addressing this issue and giving me the opportunity to include my remarks. I respectfully request that this statement be submitted for the record.

M. MURTAZA ARAIN, M.D.
CHAIRMAN
INTERNATIONAL ASSOCIATION OF AMERICAN PHYSICIANS

Chairman Waxman and members of the subcommittee, thank you for the opportunity to present the views of the International Association of American Physicians on the Health Professions Reauthorization.

The IAAP is a coalition group consisting of the American College of International Physicians, the American Association of Physicians from India, the Association of Pakistani Physicians of North America, the Association of Philippine Physicians in America and The Islamic Medical Association of North America. The IAAP represents over 40,000 physicians from many countries practicing in the U.S.

There are currently an estimated 569,000 physicians in the United States, 130,000 of whom are international medical graduates (IMGs). These physicians - 23 percent of our nation's medical doctors - are more likely to serve the disadvantaged and indigent in inner-cities, State hospitals and VA hospitals than domestic medical graduates. In Illinois, 33 percent of the practicing physicians are international medical graduates.

In 1956, due to physician manpower needs, the Educational Commission for Foreign Medical Graduates was established. The ECFMG assesses the qualification of IMGs to enter U.S. residency training. Since that time, IMGs have filled the gaps of medical care where USMGs have not been serving. IMGs can be found disproportionately to be serving in VA hospitals, mental institutions and inner-city hospitals serving the poor and uninsured. It is important to note that while 80 percent of IMGs provide direct medical care, 20 percent serve on the faculty of U.S. medical schools and teaching hospitals. 50 percent of the research physicians at the National Institutes of Health are IMGs.

These 130,000 internationally trained physicians are legal residents, most of whom are American citizens. These practicing physicians have passed U.S. medical licensing exams, received residency training in the United States and obtained a license to practice in a state.

Studies have shown that there are no discernable differences in the frequency of litigation involving the two groups and that the level of patient satisfaction is equal for the two groups. An exhaustive study by the Journal Medical Care revealed that there are no significant differences in the performance of USMG and IMG attending physicians, house staff physicians, or in the ambulatory care setting. Yet despite the significant contributions to medical care in this country that we have made, we are subjected to a two-tiered system of medical licensure.

Mr. Chairman, it has been our contention for several years that the differences in medical licensure requirements between domestic medical graduates and international medical graduates have been used as a discriminatory vehicle to create additional obstacles in licensure by endorsement for international medical graduates. Licensure by endorsement is the process whereby a licensed physician seeks medical licensure in a second state.

There has been one significant change with regard to IMGs since you last held hearings on health manpower. Organized medicine has agreed to implement a new single United States Licensing Examination scheduled to begin next year. This new licensing exam will replace the separate exams (The National Board of Medical Examiners and the Federation Licensing Examination) which were previously given to domestic and international medical graduates. The elimination of all differences in medical licensure requirements - not just in testing - is the mission of our association.

During the last Title VII reauthorization, you asked the General Accounting Office to look into discrimination practiced by medical state licensing boards against international medical graduates. That May 1990 GAO report entitled "Medical Licensing By Endorsement: Requirements Differ For Graduates Of Foreign And U.S. Medical Schools" did recommend that a national repository for physician credentials be established in order to streamline the process of state-to-state licensing. Consistent with those recommendation, the Educational Commission For Foreign Medical Graduates has worked with the Federation of State Medical Boards and the American Medical Association in developing a National Repository for physician credentials. The purpose of this repository will be to house information relevant to medical licensure for applicants in order to prevent the interminable delays experienced by international medical graduates who apply for licensure by endorsement.

Often a licensed, practicing physician must provide information to a second state licensing board that has already been provided to one state licensing board. It frequently takes much longer for a practicing IMG to process applications for licensure by endorsement than it does for domestic medical graduates because of the difficulty involved with providing the requisite information to state licensing boards from international medical schools. Document retrieval is often near impossible for IMGs and extensive delays or minimal notice of opportunity for a hearing by a State board are not uncommon. In their research, the GAO uncovered the case of an internationally trained physician who was licensed to practice in five states yet was denied licensure in a sixth state because that state's board requested information concerning the physician's medical school that he or she could not verify. That is blatant discrimination because the information asked would not be asked of a USMG who had been licensed to practice in five states. This is an example of reciprocity discrimination.

Currently state medical boards place the burden on the individual physician to prove the equivalency of his or her medical degree. A clearinghouse for applicants records will streamline the process for state-to-state licensing and will limit duplicative state efforts as well as avoid delays for practicing IMGs who seek licensure in a second state. The repository will make it easier for states to authenticate and verify educational and training credential for all physicians.

The IAAP believes that the role of a national repository for medical licensure applicants' educational backgrounds and credentials will go a long way toward ensuring high quality health care to the American public. The function of a national repository is to promote fairness in medical licensure by expediting the process of licensure by endorsement for international medical graduates as well as for domestic medical graduates.

The IAAP strongly believes that since international medical graduates will be the principal users and payors of a national clearinghouse for medical education documentation, appropriate representatives from the international medical graduate community should be actively involved in the oversight of the operation and implementation of such a repository.

While we would prefer a federally operated repository in order to ensure fairness, we recognize that there is no need for the federal government to duplicate private sector efforts to create such a repository. For this reason the IAAP supports a private organization to administer the national repository. However in order to ensure fairness, it is absolutely imperative that a coalition of IMG groups be involved in the process of oversight of the operation and implementation of the national repository. Proper oversight would be assured by the creation of an HHS advisory council whose function would be to issue recommendations to the Secretary on how to oversee the repository and to monitor the implementation of the repository for its first three years of operation.

Congressman Mervyn Dymally has introduced legislation in the House of Representatives which would create an HHS advisory council consisting of representatives from the FSMB, ECFMG, IAAP, AMA, a U.S. medical school, an international medical school and any other organizations deemed necessary by the Secretary of Health and Human Services. Congressman Solarz is introducing similar legislation today.

Mr. Chairman, the GAO report stated that while there is a consensus on the need for the clearinghouse's concept and design all relevant groups "agreed to address basic questions, such as which organization would be best suited for administering the clearinghouse and what types of information it would maintain." Other issues such as the prevention of the potential abuses of a repository and the requisite coordination with state medical boards must be addressed and implemented in a manner approved by all of the relevant interest groups to a repository. This advisory council will provide the proper forum for these very important issues to be addressed and will ensure that the views of IMGs are properly expressed.

Funding for the actual operation of a national repository for medical credentials is self-sufficient based on fees assessed to physicians who are using the service.

H.R. 319 would also prohibit discrimination in state medical licensure and reciprocity standards by prohibiting any discrepancies in requirements by the States between domestic and international medical graduates. The different licensure criteria for the two groups is a means of limiting competition.

The IAAP has comprised many cases of disparate treatment of licensed international medical graduate physicians who applied for license in another state. These differences included requirements of extremely expensive and time consuming primary source documents from medical schools and other institutions many years later, often when duplicate original documents were available from other sources. Another example was that some states required a higher FLEX (Federation Licensing Exam) score of international medical graduates than the score which is normally required of both international and domestic graduates.

Another area of discrimination which Congressman Dymally's bill addresses involves residency training and first time licensure. For initial licensure, passing the licensing examination is sufficient evidence that an IMG has medical training from an institution that has provided the necessary training. Such training includes providing the current medical literature and teaching the latest medical progress. Some hospitals and residency programs state that either no international medical graduate applicants will be considered or would only be considered with far superior qualification than USMGs. Quotas have been set for IMGs in one program in Illinois.

A third area of discrimination addressed by H.R. 319 involves employment, promotions and hospital privileges. This includes the improper use of restriction or denial of hospital privileges based on minimal charges by domestic medical graduates who were competitors in the community. Many advertisements in medical journals and other publications limit applications for positions to domestic medical graduates. Although job notices and hospital privileges that are denied to IMGs can be fought in the courts on a case by case basis, we believe that legislation addressing this aspect of discrimination is necessary.

I would like to make it clear that we do not support legislation whose purpose is to decrease the standards for licensure or reciprocity. H.R. 319 would not infringe on the principle that grants to the people of the States the right to determine who shall be licensed to practice medicine. It would not determine what a particular states requires of its licensure applicants. It would require States to eliminate the discrepancies in licensure requirements that many States have adopted. We want to eliminate discrimination and the second class citizenry that we have been experiencing. The enactment of this bill would do that. Again, we do not wish to infringe on a State's right to set standards, only to ensure that when a State sets its licensure and reciprocity requirements that discrimination is not an unknown or clandestine byproduct.

On April 25 of this year, Dr. James Todd, the Executive Vice President of the AMA said that separate treatment of IMGs is "a continued embarrassment to the medical establishment in this country." And, Mr. Chairman, you will recall that during the 1988 hearings on the reauthorization of the Health Professions, Dr. Bryant L. Galusha, then the Executive Vice President of the Federation of State Medical Boards stated that "The federal government can play a role in assisting the states in dealing with the foreign medical graduate." A recent AMA survey of IMGs indicated that the number one priority of IMGs was the elimination of discrimination through federal legislative means.

We are greatly encouraged by the implementation of a single licensing exam for all physicians, by the GAO's recommendation for a central clearinghouse to maintain and verify information on licensure applicants' educational backgrounds and credentials and by the AMA's implementation of such a clearinghouse. But there is a great need for a federal role. 74 members of the House and 5 members of the Senate cosponsored IMG anti-discrimination measures to eliminate differences in licensure requirements. It is now imperative that the Dymally bill, which would end discrimination and would establish federal oversight over a clearinghouse for medical credentials, be enacted.

STATEMENT OF THE

INTERNATIONAL SOCIETY FOR CLINICAL LABORATORY TECHNOLOGY

The International Society for Clinical Laboratory Technology (ISCLT) is pleased to present its views to the Health Subcommittee regarding the reauthorization of Title VII of the Public Health Service Act. ISCLT was founded in 1962 and is currently one of three national professional associations representing laboratory technologists and one of four private professional organizations which certify laboratory technologists.

The Committee has already received substantial testimony regarding the acute shortage of clinical laboratory personnel. This problem is particularly severe in rural and inner city areas where many of our members are employed. Studies recently conducted by the American Society of Clinical Pathologists (ASCP) and The American Society for Medical Technology (ASMT) find alarming shortages of laboratory personnel. According to the ASCP survey, vacant positions have doubled since 1988 and over two-thirds of all laboratory managers report difficulty filling openings for medical technologists.

ISCLT strongly supports H.R. 2405 which was introduced by Representative Jim Slattery (D-KS) and 42 other Members of Congress on May 20. This legislation provides a comprehensive response to the laboratory technologist shortage. The bill will help avert an even greater crisis which is likely to occur if the CLIA '88 personnel rules proposed by HHS are implemented as drafted.

H.R. 2405 has three major components. Section 2 establishes programs designed to attract more laboratory technologists to rural areas through loan repayment programs for students and financial assistance for special training programs. Section 3 requires the Secretary of HHS to develop a program for accrediting State and nonprofit entities which certify laboratory personnel. Section 4 directs the Secretary to develop and administer a competency-based examination to certify laboratory technologists until such time as the Secretary has established accreditation standards for private certifying agencies.

Each of the provisions is critical to the legislation. In particular, we would like to express our strong support for reauthorizing the HHS proficiency examination. The development and administration of an HHS proficiency exam is supported by over 22 state hospital associations, the three professional organizations representing medical technologists, and several major veterans organizations. In addition, 78 Members of Congress signed a letter to Dr. Gail Wilensky, the Administrator of HCFA, asking her to conduct this type of test.

Past examinations offered by HHS have been extremely effective at reducing the shortage of clinical laboratory personnel. Between 1975 and 1987, over 65,000 laboratory professionals took the HHS exam and 30,799 or 46.9% passed. A high percentage of the laboratory technologists practicing today in rural and inner city independent and hospital laboratories qualified through the HHS exam.

Authority to conduct this exam was eliminated in 1988 for two reasons. First, it was argued that the private professional organizations could provide an adequate supply of baccalaureate-degreed individuals to meet provider's needs. Second, the claim was made that anyone who wanted to take the HHS proficiency exam had an opportunity to do so during one of the seven administrations of the test. Irrespective of whether or not these claims were legitimate in 1988, it is clear that they are not valid today. The shortage of personnel has been thoroughly researched, documented and reported. Moreover, thousands of individuals who either have recently graduated from military and other training programs or who have been practicing in physician's offices or hospitals, have not had an opportunity to take the HHS proficiency exam.

In repealing this authority in 1988, the conferees acknowledged that future exams might be necessary:

> ". . . there may develop a shortage of such personnel in the future. If this occurs, the conferees anticipate that consideration could be given to the appropriateness of authorizing a new examination for such personnel." House Conference Report No. 100-661; May 31, 1988.

Moreover, the Energy and Commerce Committee subsequently voted to reinstate the exam as part of the 1988 Health Professions Reauthorization Bill. We urge the Committee to include a similar provision in this year's bill.

Each of the four private certification agencies currently conduct written examinations as a principal component of their own certification programs. Clearly these organizations believe that a written examination can be an important evaluator of laboratory knowledge, otherwise they would not require applicants to take these tests. We believe that these groups, working with the Secretary, can develop an examination which could be used to assess the laboratory knowledge of the personnel currently in the field.

The administration of such a test is far superior to grandfathering all existing personnel regardless of ability, as some have suggested, or to refusing to allow experienced laboratory staff to continue to practice their profession.

While not a perfect solution, this is a very realistic and reasonable approach to this problem.

We believe that absent Section 4, this legislation will not be effective in resolving the current crisis. The education loan and grant provisions and the private accreditation provisions are valuable and we hope they will make a significant contribution toward reducing the long-term problem. However, they will not provide any immediate relief to independent labs, community hospitals, and physician office laboratories.

The administration of additional proficiency exams is particularly critical for non-degreed individuals who are practicing in hospitals and physician offices. Under the old rule, these laboratory staff had little incentive to take the HHS exam because it was not required to practice in these sites. However, under the new CLIA rules, these individuals will probably lose their jobs. Many of these professionals have worked their entire careers in laboratories. They should be permitted the same opportunity as their colleagues working in independent labs to prove their competency through a proficiency exam.

For these reasons, we urge you to incorporate H.R. 2405, as introduced, in your reauthorization of Title VII. This legislation is also supported by:

American Association of Bioanalysts
American Hospital Association
American Medical Technologists
American Society for Medical Technology
House Rural Health Care Coalition
National Vietnam Veterans Coalition
Fleet Reserve Association
Air Force Association
Non-Commissioned Officers Association
Naval Reserve Association

and the following 22 state hospital associations:

Alabama Hospital Association
Arkansas Hospital Association
Colorado Hospital Association
Association of Delaware Hospitals
Iowa Hospital Association
Illinois Hospital Association
Indiana Hospital Association
Kansas Hospital Association
Kentucky Hospital Association
Louisiana Hospital Association
Massachusetts Hospital Association
Minnesota Hospital Association
Missouri Hospital Association
Montana Hospital Association
Nebraska Hospital Association
Nevada Hospital Association
North Carolina Hospital Association
Ohio Hospital Association
Oregon Hospital Association
South Dakota Hospital Association
Texas Hospital Association
Washington State Hospital Association.

National Association of Pediatric Nurse Associates & Practitioners

Mr. Chairman and distinguished Members of the Subcommittee, my name is Ruth Mullins. I am a Certified Pediatric Nurse Practitioner (CPNP), Director of the Pediatric Nurse Practitioner (PNP) program at California State University, Long Beach, California, and President of the National Association of Pediatric Nurse Associates and Practitioners (NAPNAP).

My statement is on behalf of the National Association of Pediatric Nurse Associates and Practitioners which represents over 3,300 pediatric nurse practitioners (PNPs) in the country. My statement addresses the needs of nursing education programs -- specifically, nurse practitioner programs -- as the Committee undertakes the reauthorization of Title VIII of the Public Health Service Act.

Title VIII

The Nurse Practitioner/Nurse Midwife Program is authorized under Section 822(A) of Title VIII. This program provides grants to assist eligible institutions to meet the costs of educating nurse practitioners and nurse midwives. Grants are used for programs to train nurse practitioners and nurse midwives to work in primary care settings and other health care institutions.

The original purpose of the legislation, dating back to 1964, was to increase enrollments at the various nursing schools and to assure the financial viability of schools offering these programs. Over the years, the legislation has focused on "advanced nurse training" -- i.e., PNPs. The need for this program still exists.

Pediatric Nurse Practitioners

PNPs provide basic health care and preventative services to children from birth through the age of 21. PNPs are critical links in the delivery of primary prevention services to children who traditionally have no other access to care. They staff well-baby clinics, administer immunizations, conduct screening programs and teach parenting skills, growth and development, and nutrition and safety. PNPs can independently manage a broad range of health care needs, including the management of colds, ear infections and other common childhood diseases. In addition, PNPs coordinate the management of many chronic illnesses and can deliver direct care to those children with stable chronic conditions. In essence, their practice base extends the entire spectrum of care delivery for children. PNPs are found in community health centers, health maintenance organizations (HMOs), primary care centers, private practices, and hospitals throughout the U.S.

Access to Health Care for Children

You can hardly pick up a newspaper without seeing something about the crisis in health care -- and its most innocent victims -- children. In fact, recent discussions by Congressional leaders have indicated that the health and welfare of the children in this nation will be one of the pivotal domestic programs of this decade. The health care problems of children are multifaceted ranging from access to health care, the availability of health care providers and health care delivery to medically underserved populations. Historically, the Congress has supported pediatric nurse practitioners. As a result, children in medically underserved areas have received health care that would have otherwise been unavailable to them. On behalf of these children, we thank you and your colleagues for your past support, and urge that you maintain and strengthen that support this year as you address the pressing problems of children in our society.

Authorization Request

We request a three year authorization of Section 822 as follows:

FY 1992	FY 1993	FY 1994
$23,500,000	$26,332,000	$29,400,000

In addition, we seek further emphasis, through bill and report language, that would emphasize Pediatric Nurse Practitioner programs. PNPs receive advanced training emphasizing pediatrics and child health issues. This education provides the basis for PNPs to provide primary care services without immediate supervision of a physician. Often, this occurs in medically underserved areas. Studies have found that nurse practitioners provide cost-effective care and increase the productivity of medical practices. What follows is some background information on the education of a PNP.

Education of a PNP

A PNP is a registered nurse who has completed an additional formal education program. The majority of all PNP education programs are at the Masters level. The program content includes courses in growth and development, family and cultural issues, pediatric physical and development assessment and the management of common childhood illnesses and problems. All programs have a strong clinical component. After graduation, a PNP can obtain professional certification, which is a confirmation of professional competency.

PNP Education Programs

Nurse Practitioner (NP) programs are expensive. Many educational institutions and most state supported universities cannot support or afford to offer these programs because of the high costs associated with them. Most programs average 8 - 16 students per class. The costs are due mainly to the necessary faculty-student ratios.

Today, there are 44 PNP education programs in the country. Unfortunately, only seven are receiving federal funding support through the Nurse Education Act funds. Most recently, three PNP education program applications were approved but notified they will go unfunded due to a lack of resources.

For the entire Nurse Practitioner and Nurse Midwife traineeship program, the Division of Nursing expects that there will be about 14 - 18 unfunded but approved grant applications amounting to about a $2.7 million shortfall. Last year, 13 grants for federally assisted educational programs were approved and unfunded.

We are appreciative of the support Congress has given the nurse practitioner/nurse midwife program in the past for both the authorization and appropriations. We also recognize that the funding levels have not kept pace with the authorization levels. However, in the appropriation process the nurse practitioner/midwife program has fared better than most other nurse education programs. Last year's appropriation was over $15 million. However, according to Division of Nursing Staff, after reductions and expenses are taken out for "evaluations" and other expenses, only about $13 million to $14.6 million will be realized for funding of grants.

Because of the number of meritorious programs that are going unfunded, which could make a critically important difference in the health care that is delivered to children in medically underserved areas, we urge Congress to support our authorization level request for the nurse practitioner/nurse midwife program.

We believe a higher authorization level is needed to increase the pool of money for these primary health care providers -- nurse practitioners, nurse mid-wives. Such an increase will help to spread the allocation of monies among the various specialties.

Federal funding for nursing education programs does make a difference! Without such support, the number of PNPs will decline at a time when the needs of children are ever increasing. Low birth-weight babies, immunization problems, school screening programs, substance abuse and child nutrition are but a few examples of problems which PNPs can help resolve.

PNPs Role as Health Care Provider

The demand for PNPs exceeds their number. PNP program education directors receive numerous requests for PNPs to work in a number of settings such as HMOs, schools, private practices and rural health settings and other primary care centers in medically undeserved areas. In addition, there is anecdotal information demonstrating increasing needs for PNPs in urban areas. For example, in the Los Angeles-Orange County area there are currently 15 unfilled open positions for PNPs.

The profile on America's child health has improved in some areas over the past 40 years; but problems still exist. Injuries have now replaced infectious diseases as a great concern for the health of children. Motor vehicle accidents, drownings, falls, poisoning, fires and homicide still remain problems at the top of the list.

Other primary and preventable problems include homicide, suicide, child abuse and neglect, developmental problems and lead poisoning. Some infections such as influenza and respiratory illnesses, and asthma, remain major child health problems.

Childhood is the time to focus on human development. A good health plan for children helps to prevent bad health behaviors, i.e., drug abuse, smoking, alcohol and diet -- and establishes good healthy behavior.

PNPs are well prepared to focus on these issues as well as manage and deliver this kind of health care. PNPs are an integral part of the health care team to provide primary health care services. This concept has been supported by numerous federal agencies and the Federal government.

Throughout the last 25 years, PNPs have helped to make a difference in children's health. But, there are only about 6,000 PNPs available to provide this care. Most recently, the Graduate Medical Education National Advisory Committee (GMENAC) Final Draft Report, HRSA 240-89-0041, 1991, p.5, highlighted PNPs as a potential contributor to the delivery of child health care. The GEMNAC report also suggested "the balance of care (child care) is felt to be ideally provided by non-physician professionals while medical needs would be roughly 50% higher if no care was ever delegated." (GMENAC Final Draft Report, 1991, p. 9). It also stated that there was a need for more mid-level providers and primary care nurse practitioners.

Summary

PNPs provide access to health care; however, nurses need access to education programs to obtain the necessary credentials to provide care.

Today, both of these issues are critical to address the acute problems which exist with this nation's most precious resource and hope for the future -- its children.

We respectfully request your favorable consideration in reauthorizing the nurse practitioner/midwife traineeship program at:

FY 1992	FY 1993	FY 1994
$23,500,000	$26,332,000	$29,400,000

We also request that you include language in the bill and report that would assist in fairly distributing the monies among the various nurse practitioner groups so that the specialty of pediatric nurse practitioners continues.

Thank you again for this opportunity to present our views.

STATEMENT
OF THE
NATIONAL REHABILITATION CAUCUS

Health Professions Training Act Reauthorization

The National Rehabilitation Caucus (NRC) is a coalition of organizations representing health care professionals, consumers and institutional, home and community-based providers of medical rehabilitation services. The Caucus urges Congress to address the growing shortage of medical rehabilitation professionals during the reauthorization this year of the Health Professions Training Act (Title VII, Public Health Service Act). A renewed commitment to the education and training of occupational therapists, physical therapists, respiratory therapists, speech-language pathologists, audiologists and other key rehabilitation personnel is essential to stem the escalating dimensions of existing shortages and meet the health care needs of the elderly and individuals with disabilities in the years ahead.

Legislation has been introduced by Senator Tom Harkin (D-IA) and Representative Terry Bruce (D-IL) which would expand the existing allied health education and training authorities contained in Title VII and target resources to areas of greatest need. S. 694 and H.R. 1466 would develop and expand allied health education program and faculty resources and increase student enrollments in those disciplines experiencing the most severe shortages and which will be in greatest demand into the next century. The Caucus strongly urges approval of these proposals during the Title VII reauthorization process.

Background

Hospitals, nursing facilities, home health and rehabilitation agencies and other service providers are increasingly unable to recruit sufficient numbers of qualified occupational therapists, physical therapists, respiratory therapists, speech-language pathologists and other medical rehabilitation professionals to provide essential services. The skills and services of these professionals are critically important in the provision of care to the elderly, the chronically ill and individuals with disabilities.

The personnel shortages in these professions are approaching unprecedented proportions, and will intensify in the years ahead unless Congressional action is forthcoming to assure the availability of an adequate number of practitioners. A broad range of authoritative sources provides evidence:

- The most recent American Hospital Association (AHA) human resource survey conducted among hospitals nationwide reveals, for the second year in a row, serious difficulties recruiting and retaining medical rehabilitation professionals. The highest staff vacancy rates nationally are 16.4 percent for physical therapists and 13.6 percent for occupational therapists. Other professions classified as personnel shortage categories include speech-language pathologists (9.9 percent), respiratory therapists (8.9 percent) and occupational therapy assistants (8.2 percent). These shortages are being experienced by rural and urban hospitals alike. Vacancy rates in many individual states have reached such serious levels that hospitals are responding by reducing services, closing beds or units and diverting patients to other facilities when medically appropriate. These staff shortages are also confirmed in a staff study conducted by the Prospective Payment Assessment Commission (ProPAC).

- The U.S. Department of Veterans Affairs (VA) medical system is experiencing even more severe recruitment and retention difficulties. The most recent fiscal year 1991 data show vacancy rates for physical therapists at 27.3 percent and vacancy rates for occupational therapists at 18.8 percent.

- The U.S. Department of Health and Human Services' 1990 **Annual Report to the President and Congress on the Status of Health Personnel in the United States** noted that "...the allied health field is faced with growing shortages of personnel in a number of critical professional categories, reductions in program enrollments, closures of training programs, underrepresentation of minorities and shortages in faculty and trained researchers".

Additional reports from the Institute of Medicine, the U.S. Department of Education, the Institute on Aging, the American Medical Association, the National Easter Seal Society and the American Association of Retired Persons underscore the growing threat these shortages represent to our nation's ability to provide important health and rehabilitation services.

A principle factor contributing to these shortages is the escalating demand for services from a population with more individuals surviving into old age, frequently with chronic conditions or multiple disabilities. According to the 1990 HHS report, "As the number of elderly increases, the demand for allied health practitioners in a variety of fields will rise accordingly, and combined with greater longevity will have a significant impact on demand for practitioners in rehabilitation fields such as occupational therapy, physical therapy, respiratory therapy and audiology." Further, advancements in medicine and technology have increased the frequency of survival from from accidental trauma or severely disabling conditions present at birth, thereby heighting demand for services to enhance functional independence and quality of life.

Future Demand

Future projections illustrate the need for Congress to take action now if a crisis in health care is to be averted in the years ahead. The National Academy of Sciences' Institute of Medicine, in a major study conducted in 1988, noted that unless Federal policymakers intervene the nation will suffer from a "serious shortage of allied health professionals". More specifically, the IoM projected that the most serious personnel shortages by the year 2000 could occur in the fields of occupational and physical therapy.

U.S. Department of Labor estimates lend further credence to this warning. Projections by the Bureau of Labor Statistics indicate that between now and the turn of the century, the nationwide demand for physical therapists and occupational therapists will increase by 57 percent and 49 percent respectively, with 34 percent increases for speech-language pathology and respiratory therapy, and similar increases for other allied health professionals.

Title VII

In addition to significantly increased demand for services, a serious lack of focused Federal support for the education and training of allied health professionals generally, and medical rehabilitation professionals specifically, has compounded the personnel shortages currently being experienced. While historically the Title VII health professions programs represented the primary source of Federal support for the training of allied health professionals, authorization and appropriations for these programs ended after 1980. Some modest initiatives to redress this situation were enacted when Congress reauthorized the Title VII programs in 1988. However, annual authorization levels targeted to allied health totaled only $6 million, and appropriations over the three year period totaled only $2.3 million.

The educational system for rehabilitation professionals has not been able to meet the surging demand. This inability to produce an ample supply of qualified practitioners is caused by a variety of factors including an inadequate supply of faculty, an inability to increase class sizes because of a lack of resources, a shortage of education programs in some professions, and a decrease in funds for scholarships to attract students into programs.

Recommendations

The Caucus strongly urges Congress to build on the modest initiatives incorporated into the 1988 reauthorization of Title VII by adopting the provisions contained in the legislation introduced by Senator Harkin and Representative Bruce. These provisions would target Federal support to those allied health fields or specialties that are experiencing the most severe personnel shortages. The legislation would also seek to meet the future needs of the nation's aging population and those with disabilities by directing support to those fields which play a significant role in the care and rehabilitation of the elderly or disabled. The proposals will assist in expanding existing allied health education programs and in the creation of new programs, will address the shortage of qualified faculty, and will provide incentives for attracting individuals into key allied health professions.

The specific provisions of S. 694/H.R 1466 are as follows:

Allied Health Project Grants - This section would authorize the Secretary of H.H.S. to make grants and enter into contracts with schools of allied health to assist in the improvement and expansion of education programs and faculty resources and to assist in the recruitment of individuals into allied health professions. The Secretary is required to direct 75 percent of the funds to support programs in those fields or specialties that have substantial shortages and play a significant role in the rehabilitation of elderly persons or individuals with disabilities. Authorization levels under this section would be $7 million in fiscal year 1992, $9 million in FY '93 and $11 million in FY '94.

Traineeships for Advanced Training - This section would authorize grants to schools of allied health to assist them in the development and operation of post-graduate programs for the advanced specialty training of allied health professionals who plan to teach and to provide assistance to post-graduate students in the form of traineeships or fellowships.

Support under this section would be directed to those fields or specialties that have significant shortages, insufficient numbers of faculty, and a significant role in the care and rehabilitation of elderly persons or individuals with disabilities. Authorization levels proposed are $7 million in fiscal year 1992, $9 million in FY '93 and $11 million in FY '94.

Entry Level Student Traineeships - This section would authorize grants to schools of allied health to assist students in meeting the costs of entry level education, with 75 percent of the funds targeted to fields or specialties having the most significant shortages and a significant role in the care and rehabilitation of the elderly persons or individuals with disabilities. Authorization levels for this section are $10 million in fiscal year 1992, $12 million in FY '93 and $14 million in FY '94

Advisory Council on Allied Health - The legislation would establish a new Advisory Council to provide advice and recommendations to the Secretary of H.H.S. and the Congress on policy matters relating to the education and training of allied health professionals.

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

Area Health Education Centers Program
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June 14, 1991

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
2418 Rayburn House Office Building
Washington, DC 20515

Dear Mr. Waxman:

On behalf of the Directors of Area Health Education Center (AHEC) Projects serving 34 states, I am sending this statement for the record to you as Chairman of the Subcommittee on Health and the Environment. The statement includes two requests relative to the future of the National AHEC Program and the Health Education and Training Center (HETC) Program. First we ask that the National AHEC Program and the HETC Program be maintained through the reauthorization of Title 7 of the Public Health Service Act. Second, we ask that modifications be made in the authorization levels of both Programs and that a new type of AHEC be added to the authority. These new AHECs would be called "state-supported AHECs" to indicate that their survival has withstood the termination of federal AHEC funding by virtue of stable state and local funding but that they can continue to serve federal goals for improved access to health care for underserved populations through the continued availability of modest levels of federal funds through a matching arrangement.

The AHEC Concept

The AHEC concept was set forth by the Carnegie Commission in its 1970 Report, "Higher Education and the Nation's Health." Facing serious erosion in the ability of our nation's rural and inner city communities to recruit, retain, and keep physicians and other health professionals up-to-date, AHEC was proposed as a new type of regional education and training center that would link university health science centers with underserved communities in order to improve access to health care services. Prior to the creation of AHECs, outreach by university health science centers to communities resembled the many spokes on a wheel. It was apparent that this type of outreach was inefficient and of limited capacity considering the great number of underserved communities that could benefit from professional development activities in association with the university.

AHECs have dramatically altered the capacity for university outreach to underserved communities on a national scale. Insofar as one university health science center may work with five or more regional centers (AHECs) and insofar as each AHEC works with communities in several rural counties or inner city neighborhoods, it can be shown that the National AHEC Program has brought education and training programs to rural and inner city communities throughout the nation. Many of these communities are in some of the most underserved parts of our nation ranging from the Mexican border, to the Caribbean Basin, to frontier areas, to Appalachia, to the inner city areas of Cleveland, Atlanta, Boston and Miami, and to the vast reaches of Alaska and northern Maine.

AHECs are corporate entities based in communities that are geographically distant from the university health science center. Most are also administratively separate from universities and negotiate relationships between both the university and community service agencies to bring educational programs to the community. Education and training programs cover the continuum of the educational process for all types of health professionals and support personnel. Programs encompass allied health (e.g., physical therapy, occupational therapy, laboratory technology, etc.), dentistry, medicine (both allopathic and osteopathic), mental health, nursing, pharmacy, public health, social work, etc.

AHEC Accomplishments

Programs are conducted in the following categories:

1. Health Science Student Rotations

   - Many thousands of medical, nursing, and health science students are rotated from universities to community settings each year. These rotations expose students to community practice, to primary care, and to community practitioners. Since 1972, a generation of students has had the opportunity to broaden its educational base, to become involved in interdisciplinary curricula and to observe community practice because of AHEC. Several states have data to show that these activities have been associated with an increased retention of students in their states and, specifically, in underserved areas.

2. Interns and Residents

- Thousands of interns and residents have also benefitted from training in AHEC settings. Some, such as those in Arkansas and North Carolina, have received their entire training in AHECs. In other states, residents have rotated from university hospitals to community hospitals, community health centers, public health departments, and/or private practitioners' offices for parts of their training.

  Since these internships and residencies are largely in the primary care fields of family practice, internal medicine, pediatrics, and obstetrics-gynecology, the National AHEC Program has been a mainstay in the federal strategy not only to increase the number of primary care physicians but to increase the likelihood that they will settle in underserved communities. In North Carolina, for example, for the 177 physicians who did a primary care residency in an AHEC between 1977-1988 and who also attended medical school in North Carolina, 84 percent (149) are practicing in the state and about 40 percent originally settled in towns of under 10,000 people. This type of accomplishment helps make the case that AHEC has been responsive to its Congressional mandate.

3. Off-campus Degrees

- While traditional AHEC activities include the rotation of university-based students to community settings, it is clear that there are many health practitioners already at work in underserved communities who would like to increase their level of education and training but who are not able to leave their jobs and families to obtain a higher level degree through studies at a distant university campus. This situation is tragic both for the individual and for the community which does not gain the benefit of the higher level of services the practitioner could provide.

  AHEC has helped overcome this dilemma by bringing university degree-granting programs to community settings. Each day, faculty in different parts of the country travel to AHEC sites to conduct classes that offer the same degree that is offered to on-campus students. For example, nursing faculty might travel to an AHEC site one day per week over three years in order to teach a cohort of 30 practicing nurses who come from a variety of community hospitals, public health departments, community health centers, public schools, and nursing homes and who receive their baccalaureate degree in nursing after three years of one-day-per-week study at the AHEC. The nurses never leave their jobs or their families. The community is enriched even as the university has taken another step to become a university without walls.

4. Continuing Education

- One of the challenges facing our underserved communities is that of helping to keep practitioners up to date with the latest in medical information and technology. AHEC helps communities accomplish this. Each day, AHECs throughout the nation conduct hundreds of formally organized and professional credit bearing continuing education programs for all types of health practitioners throughout their service regions. While we have no accurate head counts, we estimate that there are at least one million participants in these continuing education activities each year. Insofar as AHECs conduct these programs both at the AHEC site and in communities throughout their service areas, the National AHEC Program can demonstrate that thousands of counties actually have AHEC programs conducted in them each year. These programs reflect AHEC's ability to respond to current health issues and needs such as AIDS, infant mortality, health promotion/disease prevention, aging, substance abuse and to assist with the rapid dissemination of the latest in research findings from NIH funded research. The demonstrated level of disciplinary and interdisciplinary programming suggests that AHEC may well be on its way to becoming one of the major mechanisms for transferring newly discovered information to practitioners throughout the nation.

  These activities help not only to keep practitioners up-to-date but also serve as an important form of professional stimulation for practitioners who would otherwise be isolated. It can reasonably be expected that the presence of these educational programs can help in the recruitment of practitioners to underserved areas and in their retention once they have set up practice in an underserved community. Certainly, they also help keep practitioners up-to-date with the latest medical information.

5. Technical Assistance

- While it is relatively easy to demonstrate that AHECs have been involved in the training of students and residents and in the provision of continuing education programs, it is more difficult to demonstrate another important activity of the AHECs. This activity is the provision of technical assistance or professional support services to practitioners in underserved communities. Thousands of AHEC-based faculty and staff have direct communication with practitioners in underserved communities on a daily basis. These contacts often result in the provision of individualized consultative services that help practitioners with their daily problems. For example, in many parts of our nation, nursing directors of small hospitals are chosen from the ranks of practicing nurses who have done a good job of clinical nursing in their hospital. Regrettably, most of these new nursing service directors receive very little in the way of training on how to make the transition from clinical nurse to administrative nurse. As a result, they often do a poor job of administration and often resign in frustration.

AHEC not only helps such nurses through formal continuing education programs on nursing management and administration, but, more importantly, brings nurse consultants to the community hospital or service agency to help the new nursing director with her specific needs. This help might include having consultants who describe how to develop a budget, how to develop a staffing plan, how to recruit new nurses, how to improve in-service education programs, etc. While it is impossible to quantify the extent of these services that are provided throughout the nation on a daily basis, testimony from practitioners who receive them indicate that such services are vital to their existence and to their retention in their current practice location. Through these mechanisms, the AHEC Program contributes both to the quality and to the distribution of health services in underserved communities.

6. Minority Manpower Development

One of the special facets in our concern for the geographic distribution of primary care health manpower relates to the inadequate number of minority citizens who have chosen careers as health professionals. One major focus of AHEC projects throughout the nation has been to increase the number of native Americans, Afro-Americans, Hispanic Americans, and other minorities in health careers.

AHEC projects routinely conduct programs that reach students at the junior and senior high school levels as well as mid-career persons to encourage them to consider health careers. Most of these programs focus on the minority population. AHECs conduct health fairs, summer health careers camps, "shadowing" experiences whereby minority students get to follow practitioners during their daily routines, and other activities. Many AHECs run programs that help train high school guidance counselors and health occupation teachers so they may better orient and recruit students to health careers. Other AHECs have developed health careers reference manuals and other educational materials for recruitment to the health professions.

In addition, several AHECs work with their affiliated health science schools to conduct programs that increase the retention of minority students once they have enrolled in a health science school. Many AHECs also target recruitment activities toward minority students at the time of their graduation from health science schools in order to encourage them to practice in communities in AHEC regions. Testimony has been received from throughout the country from consumer action groups as well as from academic groups attesting to the quality and to the importance of these minority health career development programs conducted by AHECs throughout the nation.

7. Library and Information Services

The AHEC Program works because it is a bridge between the academic community and both the rural and underserved inner city communities through an intermediary organization called the Area Health Education Center. Communication and information exchange are the hallmarks of a successful AHEC Project. Communication takes many forms and includes regular visits by faculty to community settings, by students who study in community settings, and by community practitioners who visit the academic centers in order to bring the realities of the work place to the classroom.

Another kind of communication relates to the flow of information that derives from the latest findings in medical and health services research. Libraries and their associated information services networks have been developed by many AHECs throughout the nation and have become the essential underpinning of AHEC's work. Major library networks linking underserved communities with AHEC libraries and subsequently with the major libraries of the affiliated academic health science center and through them with the National Library of Medicine have been developed. In several states, computer linkages have been formed between AHEC libraries and the libraries in smaller hospitals, public health departments, mental health centers, practitioner offices, and other service delivery sites throughout the regions.

Literally hundreds of thousands of information exchanges in the form of inter-library loans, medical literature searches, etc., take place on a daily basis. No longer are practitioners in underserved areas isolated from up-to-date information. As was noted in the description of continuing education activities, the AHEC library and information services networks are major conduits for communicating the latest information concerning health care services and technology to practitioners. In turn, these services help lessen professional isolation and make it much more likely that underserved communities can recruit, retain, and keep health care practitioners of all types up-to-date.

AHEC: Re-authorizing a National Resource

Those who are associated with the National AHEC Program believe that the many activities and accomplishments outlined above indicate that AHECs have become a national resource for linking academic centers with underserved communities through regional education and training centers. But the accomplishments of AHEC do not reside solely in the program activities already described.

The broad social goal of AHEC is to improve the distribution of primary care practitioners in underserved communities, and at the same time, to increase the quality of their practice. Data exist in several states which show that improvements have been made in the distribution of primary care practitioners in underserved communities served by AHEC activities. In addition, some data exist to indicate that the quality of health care services has been improved through activities associated with the AHEC Program.

Regrettably, improvement in complex social conditions such as the geographic distribution of health practitioners is nothing that is "solved overnight and for all time". Regular attention to such conditions is needed if our underserved communities are not only to recruit practitioners but to retain them over time. There will always be an "ebb and flow" in the number of practitioners in any particular underserved area. For this reason, communities will forever need to give attention to the quality of the professional practice environment and to the recruitment and retention of practitioners within that environment. **Insofar as this is likely to be a long term struggle, especially in view of the declining economic base of rural and inner city America, the network of Area Health Education Centers that has been created throughout the United States of America must be viewed as a national resource that must be protected and nurtured in order to continuously provide underserved communities with a measure of assistance previously unknown to them.** In fact, even in face of the strong support given by the federal government to community health centers, the National Health Service Corps, primary care training programs and AHEC during the past five years, there has been, following a decade of progress, a recent decline in the supply of primary care practitioners in rural and inner city areas. Many observers believe the decline would have been substantially greater had it not been for the activities of primary care training programs, the National Health Service Corps, the community health centers and the Area Health Education Centers Program.

Based on the belief that the National AHEC Program has become a national resource and that this resource must be continued over time, just as the federal government has supported community health centers in underserved communities over time, the following suggestions are offered relative to the reauthorization of the National AHEC Program and the HETC Program through Title 7 of the Public Health Service Act. These suggestions have the support of the AHEC Project Directors from throughout the nation. They are offered in four categories:

1. The Basic AHEC Program
2. The HETC Program
3. "State-Funded" AHECs - a new type of AHEC
4. Reauthorization Levels

1. The Basic AHEC Program

The Basic AHEC Program, as currently authorized in Title 7, should be reauthorized to allow for continuation of three types of projects, (a) New Starts, (b) Completion of Existing Obligations, and (c) Special Initiatives. Within each of these we have some specific suggestions.

(a) New Starts
While medical schools in a few states may still bid for new AHEC Projects, it is expected that within the next three to five years most states will have already gotten into AHEC activities. While the reauthorization should continue to allow for new starts it seems reasonable to have the long term funding of AHEC recognize the fact that fewer new projects will be forthcoming.

(b) Continuation of Existing Obligations
The Secretary has existing obligations to AHEC Projects in several states. The reauthorization must allow for the completion of these projects. We suggest, however, that the statute be changed to allow each center within a given project to have a maximum of six years of federal "start-up" funding, eliminating the current policy that allows a maximum of nine years for a given project regardless of when it brings its various centers on-line.

At the same time we support making matching requirements more stringent so that projects must show a $1.00 match for each $1.00 federal by the seventh year of the project.

(c) Special Initiatives
This is a small but increasingly critical part of the AHEC authority. It allows AHEC Projects that (i) have completed their multi-year cycle of federal funding and (ii) continue to exist through state and local funds to bid competitively for small federal AHEC grants over a one to two year basis. These grants allow the federal government to continue to use the many AHEC networks it has so carefully developed in order to have these networks continue to meet federal goals for their target communities.

The Special Initiative Authority has stimulated many excellent activities that have contributed to improved access to primary care services for many underserved population groups. In most instances these modest federal AHEC grants have been substantially enhanced by their ability to mobilize local and state AHEC resources to work together to help meet the federal objectives.

The Special Initiative Authority is facing a serious challenge, however. Each year, more AHEC Projects complete their cycle of federal funding and become eligible for Special Initiative funding. In a few years there will be more projects in this category than there will be projects that receive federal funding. It would be tragic for the federal government to ignore the potential these AHEC networks offer to meet federal goals.

As an example of the unused potential facing the federal government, we understand that in the most recent cycle of federal reviews of Special Initiatives there were about $1.83 million of Special Initiative proposals that were approved but unfunded. These approved proposals would have allowed several AHEC Projects to continue to address federal goals for increased access to health care services for underserved populations, but now these potential projects lie dormant.

Therefore, we urge that the AHEC reauthorization raise the authority for Special Initiative to 20 percent of the funds appropriated for AHEC or to higher percentage levels if the concept of "state-supported AHECs" is not authorized (see #4 below).

2. The HETC Program

We believe the HETC Program should continue in its established format but we would favor that each HETC Project require the participation of a School of Public Health if one exists in the HETC service region and if the School desires to participate.

3. State-supported AHECs: a new type of AHEC

The first part of this statement was designed to show that the National AHEC Program has resulted in the creation of AHEC networks in several states that have resulted in a dramatic increase in the number of medical and health professions education programs taking place in rural and inner city areas. Further, the statement has made reference to the fact that AHEC networks have contributed to the improved geographic distribution and quality of primary care services.

What has not been explicitly stated in the way of an AHEC accomplishment is that many states and communities have committed substantial resources to their AHEC projects in response to the catalytic effect of federal AHEC funds. For the 21 projects currently receiving federal AHEC funding from the current appropriation of about $18 million, there is a state/local match that ranges from 25-84 percent for the various projects. For the 15 projects that no longer receive federal AHEC funding there is a wide range of state/local support.

The continuation of many AHEC Projects through state/local funding confirms the value of the AHEC projects to the communities they serve. It also shows that the federal government has the opportunity to capitalize on the existence of these projects in order to have them continue to meet federal goals.

- The "State-supported AHEC" authority should allow the federal government to continue to support AHEC projects with matching funds that would provide $1.00 federal for every $1.00 state not to exceed $250,000 per AHEC site or $2 million per state, which ever is less.

- Through this mechanism the federal government would acquire the leverage to have established AHEC networks continue to be responsive to federal goals relative to access to health care services in underserved areas. Federal support would also give AHEC projects the added leverage to assure that states increase, or at least maintain, their level of commitment to AHEC.

- As noted earlier, insofar as the problem of access to health care in underserved areas requires long term focused attention and insofar as the activities of AHEC are one important piece of the solution to the problem it is important to recognize the need to continue to build upon the AHEC networks so carefully developed by the federal government. With time it would be exciting to see a nationwide network of AHECs that have a long term obligation to address the needs for an equitable distribution of primary care services and for the dissemination of the latest medical information to practitioners while maintaining a focus on the special needs of the minority population. The "State-supported AHEC" concept would allow this to happen.

4. Reauthorization Levels

The AHEC Project Directors believe that the following levels of authorization can be justified by virtue of the accomplishments and the potential of the National AHEC Program and the National HETC Program.

A. Basic AHEC

- **The following display of decreased funding of the Basic AHEC Authority is possible only if the subsequent proposal for "State-supported AHECs" in item B is authorized.** The decremental funding proposal should be able to cover existing obligations to AHEC Projects while also recognizing the smaller number of new starts that are expected in coming years. Special initiative funding should be increased to 20 percent per year.

  - FY '92 $20 million
  - FY '93 $18 million
  - FY '94 $16 million
  - FY '95 $15 million
  - FY '96 $14 million

  Special initiative 20%

- special initiative funding should be increased to 20 percent in each year

B. State-supported AHEC

FY '92	$18 million
FY '93	$24 million
FY '94	$30 million
FY '95	$36 million
FY '96	$42 million

C. HETC

FY '92	$ 8 million
FY '93	$12 million
FY '94	$16 million
FY '95	$17 million
FY '96	$18 million

Major Concern

If the above item B, "State-supported AHEC", is not authorized then the Basic AHEC Authority must not decrease as shown above. Rather, it should be increased at an incremental rate over the next three years until the "State-supported AHEC" can be authorized. At the same time, the Special Initiative Authority should also increase above 20 percent in moderate increments each year so as to have the net amount of the Basic AHEC Authority that is available to new starts and continuing obligations roughly equal the decremental proposal above. The added increments for Special Initiative Funding recognize the increasing number of AHEC Projects that will be eligible for Special Initiative Funding in the coming years. The added increments will allow these projects to continue to address national needs for improved access to health care in underserved areas.

Thank you for your willingness to consider the many points in this letter. We have been appreciative of the support you and the Subcommittee have given us in the past. We believe we have fulfilled the mandate given to us by The Congress and we look forward to continuing to have our AHEC networks meet national goals relative to access to care in underserved areas.

Sincerely,

Eugene S. Mayer, M.D.
Associate Dean
AHEC Program Director
(Chairman, National AHEC Directors' Legislative Committee)

STATEMENT OF THE
SOCIETY OF GENERAL INTERNAL MEDICINE
TO THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
HOUSE ENERGY AND COMMERCE COMMITTEE

JUNE 13, 1991

The Society of General Internal Medicine (SGIM), a national organization committed to promoting improved patient care, teaching, and research in primary care general internal medicine, is pleased to make its recommendations concerning the reauthorization of Title VII of the Public Health Service Act. We are particularly concerned with Section 784, the General Internal Medicine and Pediatrics program.

We are grateful for the strong support for primary care training programs which the Health and Environment Subcommittee has shown through the establishment and regular reauthorization of Title VII programs. Without this Committee's long-standing support, many primary care training programs across the country would not exist, and the United States would be facing an even larger deficit of general internists, pediatricians, and family practitioners than we are currently experiencing.

Although there was increasing concern during the early 1980's that this country would soon have an overall surplus of physicians, it has instead become increasingly obvious that, regardless of the total number of physicians, we have a serious dearth of primary care doctors. A study sponsored by the Health Resources and Services Administration (HRSA) in 1990 found that a mismatch exists between the proportion of primary care physicians needed (about 70%) and the proportion in practice (about 30%). We are, therefore, particularly concerned that in its annual survey of graduating medical students, the Association of American Medical Colleges has found a decline since 1988 in the number choosing primary care careers. Moreover, in the 1991 National Resident Matching Program, 147 fewer U.S. medical school seniors matched than last year, with only 51% of the primary care positions filled.

In light of its own data on the primary care physician deficit and repeatedly acknowledged concern about medically underserved populations, particularly in rural areas, it is surprising that the Administration has not recommended reauthorization of the primary care residency training programs in Title VII.

These programs are now more vital to the country than ever as we consider the future of our health care system. When the Title VII programs were established more than a decade ago, there was little attention paid to the need for a restructured health system. Today, however, those concerned with health care policy recognize the need for basic changes in a system which, despite its quality and technological advances, still fails to be accessible or affordable to millions of Americans. Whatever modifications we adopt for our system of care, we will need to train more, not fewer, primary care physicians to serve as the principal source of medical care.

Not only do primary care programs train the physicians we need to meet supply shortages, but they also provide the specific skills which are critical to meeting one of the challenges of the high cost of health care. We in general internal medicine, as do all primary care specialties, teach cost-effective medical practice to our interns and residents. When hospitalization is required, our students learn that facilitating the patient's speedy return to independence is the responsibility of the cost efficient primary care doctor.

Over the past several years, there has been a national recognition that hospital care is expensive, and most of this care can be better provided in other settings. Medical care is being moved out of hospitals, and primary care training programs make this change to lower cost settings possible. In general internal medicine training, our residents spend from 20 to 25% of their time in ambulatory settings such as community health centers, ambulatory care clinics, physicians' offices, shelters for the homeless, and making house calls.

In all such programs, residents work side by side with skilled faculty preceptors who not only supervise their practice experience and case management, but also serve as role models. These preceptors demonstrate to young physicians that a career in primary care can be rewarding and intellectually challenging. Through such training, residents become familiar with the community and become knowledgeable about its characteristics and problems. Without physicians trained in this manner, we will not be able to meet the crises, such as rising infant mortality, drug and alcohol addiction, AIDS epidemic, and the growing need for geriatric care. These problems must all be solved within the community more than in the inpatient or nursing home setting.

Medical students also benefit greatly from community-based training. Studies indicate that positive, rewarding clerkship experiences for third and fourth year students are important determinants for their ultimate career choices. Primary care clerkships which provide for closely supervised experiences under preceptors in both hospital and community practice settings vitally influence medical student career choices in primary care.

SGIM recommends that this authorization legislation include language supporting pre-doctoral ambulatory training for medical students in general internal medicine and general pediatrics. Similar language exists in the current legislation for family medicine and has been successful. We recommend that these pre-doctoral clerkships in general internal medicine and general pediatrics be funded at $2 million for FY 1992, $3 million for FY 1993, and $4 million for FY 1994.

Why should the Federal Government support primary care residency training when it does not similarly target funds for other medical specialties? The answers are clear: no other specialty faces such a profound physician shortage with such potential negative impact on our communities. Moreover, loss of Federal funding cannot be made up by medical schools or hospitals. Although primary care medicine itself is cost-effective for society, the training of residents in outpatient care is expensive, with no mechanism at present for the teaching institution to recover these costs. Without Federal support, many of these training programs would be either greatly limited or even terminated.

We are concerned that the Committee is considering the inclusion of HR 2231 in the reauthorization for Title VII residency training programs in general internal medicine and general pediatrics. This bill has been introduced by Representative Jim Cooper. It would prohibit institutions from receiving Title VII training funds for general internal medicine or pediatric residency programs if they do not have clinical instruction programs in family medicine.

SGIM is strongly opposed to this provision for the following four reasons:

1. The average Title VII grant of $120,000 per hospital-based residency training program in internal medicine or pediatrics will have no influence on decisions regarding the development of departments of family medicine at the affiliated medical schools.
2. Family oriented training is a well-established part of primary care curricula in the primary care residency programs of general internal medicine and general pediatrics.
3. This stipulation will reduce the total number of primary care training programs in the nation and could eliminate some of the most successful primary care residency and faculty development programs in general internal medicine and general pediatrics.

4. This provision would set a precedent of the Federal Government determining medical education curriculum.

During the process of reauthorization this year, a very cordial collaboration has been developed among the representatives of the societies mentioned above and also the American Academy of Family Physicians, the American College of Physicians, the Association of American Medical Colleges, and the Association of Professors of Medicine. Given the primary care crisis, it is vitally important that this collaboration continue. The legislation proposed by Representative Cooper will seriously complicate such collaboration and therefore SGIM opposes it for all of the reasons listed.

SGIM is in no way opposed to family medicine training. Indeed, SGIM has been collaborating closely with leaders from family medicine. Leaders from the three primary care disciplines have been collaborating closely for a number of years. This collaboration has resulted in the creation of a joint certifying examination in geriatrics, in collaborative programs for faculty development, and in joint participation at the Annual Meetings of three primary care societies (the Society of General Internal Medicine, the Society of Teachers of Family Medicine, and the Ambulatory Pediatric Association). This collaboration has not only strengthened general internal medicine and general pediatrics, but it has also strengthened departments of family medicine.

SGIM is also concerned about a proposal advanced by the Administration to phase out the HEAL loan programs. We are strongly committed to the principle that America's physicians should be drawn from all sectors of the population. This principle was articulated by John Millis in his report entitled "A Rational Public Policy for Medical Education and its Financing", in 1971. While the HEAL loans are the loans of last resort because of their high interest rates and payment requirements, these loans do make it possible for bright students from all socio-economic backgrounds to attend medical school. Unless expanded funds, or new programs are initiated, cancellation of this loan program will limit careers in medicine to individuals from middle and upper class economic backgrounds. SGIM believes that all qualified students regardless of their families' incomes should be able to pursue medical careers. The Federal Government should be expanding financial aid alternatives, not eliminating them.

The Federal Government and the institutions training the next generation of health professionals must continue the partnership to reduce the deficit of primary care physicians and meet the health care needs of our local communities. Although achieving this will entail an increased financial commitment, we are not asking Congress in this period of limited financial resources to assume a disproportionate share of the cost of achieving our mutual goal. Over the life of the reauthorization we seek a $16 million increase, $9 million of the increase to fund a new pre-doctoral clerkship program as mentioned. Specifically, we request the Committee to authorize the following levels: for FY 1992 -- $27 million; FY 1993 -- $31 million; FY 1994 -- $36 million. We strongly believe that the goal to meet the national primary care shortage justifies this moderate increase in general internal medicine and general pediatrics funding, and we respectfully urge the Subcommittee to adopt these authorization levels.

Statement of
the
Society of Nuclear Medicine Technologist Section

The Society of Nuclear Medicine Technologist Section strongly supports the reauthorization of Title VII of the Public Health Service Act and appropriations necessary to revitalize essential training programs for the allied health professions. The Society of Nuclear Medicine is a scientific organization of over 10,000 members, including 5,000 members of the Technologist Section.

Nuclear medicine is the medical specialty that uses small amounts of radioactive materials for diagnostic and therapeutic procedures. There are approximately 10 million diagnostic nuclear medicine procedures performed annually in the United States. One of every three hospital inpatients is likely to undergo a nuclear medicine procedure. The nuclear medicine technologist (NMT), under the supervision of a physician, directs or participates in the daily operation of the nuclear medicine department. The responsibilities of the NMT are varied and include: preparing and administering radiopharmaceuticals; positioning patients for imaging procedures; interacting with patients; operating nuclear medicine equipment; maintaining radiation safety; analyzing biologic specimens; computer data analysis and performing quality control measurements.

The decline in the number of allied health professionals, compounded by an increased demand, has created a crisis situation in the American health care system that threatens access to quality medical care. This crisis is also apparent in the field of nuclear medicine as hospitals and training programs have been unable to achieve their goals in recruitment and retention efforts for qualified nuclear medicine technologists at a critical time when the available technology has greatly enhanced diagnostic and therapeutic capabilities.

According to statistics from the Joint Review Committee on Educational Programs in Nuclear Medicine Technology, for the academic year 1988 - 1989, the enrollment was approximately 73% of student capacity. Data for 1990 from the Committee on Allied Health Education and Accreditation indicates that there are 110 accredited nuclear medicine technology programs, a decrease of 22% from 1985. The Nuclear Medicine Technology Certification Board (NMTCB) reported that for the period 1985 - 90 there has been an 18% decrease in the number of applicants taking and passing its examination. Ultimately, decreases in enrollees and prospective examinees result in fewer practitioners.

In 1987, the Technologist Section conducted a survey of the directors of departments of nuclear medicine to determine the impact of the Prospective Payment System (PPS) on the delivery of nuclear medicine services. Over 34% of the respondents required more than three months to fill a technologist position. Forty-three percent (43%) of the respondents indicated that there had been a decrease in the supply of nuclear medicine technologists in their area. In regard to the perception of the supply of nuclear medicine technologists in their geographic area, 57% of the respondents perceived a shortage as compared to 19% in 1984 in the Technologist Section's Human Resource Survey. Similar responses are reflected in the American Hospital Association's (AHA) 1989 Survey of Human Resources. According to the AHA survey, the full-time vacancy rate for nuclear medicine technologists is 8.9%; seven percent is the baseline used in the survey to define a shortage. It is interesting to note that the U. S. Labor Department projected a 30% increase in jobs in the U. S. between 1988 and 2000 for nuclear medicine technologists.

Since the advent of the Prospective Payment System in 1983, cost control has become a decisive factor in hospital management. These changes in reimbursement and a shift in utilization from inpatient to outpatient diagnostic imaging centers have contributed to the shortage of qualified nuclear medicine technologists with the closing of hospital based training programs which are recorded as non-revenue producing. Technological advances have resulted in an increase in the types and complexity of diagnostic imaging procedures being performed. Nuclear medicine exams are cost effective diagnostic tests and are expected to be utilized even more in the future, given the cost control initiatives implemented by health care providers and insurers.

The Society of Nuclear Medicine Technologist Section has been active in developing and implementing recruitment strategies that promote and market nuclear medicine technology as a career through public relations activities and the development of scholarship funds. However, Federal assistance is necessary to aid individual educational programs in implementing their own recruitment efforts. In addition, Federal assistance is needed to help nuclear medicine schools recruit and retain qualified faculty. The Technologist Section is offering assistance in this area by sponsoring workshops each year for educators, focusing on topics such as clinical evaluation, curriculum development, and faculty development and retention.

As quality of care and access to health care are dominant themes in the health care delivery system, consideration must be given to the implications of the decreased number of nuclear medicine technologists. Specifically, as the patient population ages, more nuclear medicine procedures will be performed to detect cancer, neurological diseases and cardiac diseases.

Significant implications in the clinical applications of radioisotope imaging have evolved in the last decade as a result of new indications for established radiopharmaceutical procedures, the refinement of imaging modalities and the approval of new radiopharmaceuticals. NMTs will require additional training in order to perform the more complex procedures. The current shortage of NMT's aggravates this problem, and if allowed to persist, will severely curtail the provision of critical medical services.

The Technologist Section is gravely concerned about the declining applicant pool of qualified nuclear medicine technologists. We fully support the recommendations of the American Society of Allied Health Professions (ASAHP) for fiscal year 1992 to reauthorize and amend Title VII of the Public Health Service Act:

- Entry-level education traineeships ($12 million) -- grants to educational programs to assist students in meeting the costs of entry-level education;
- Advanced-level traineeships ($12 million) -- grants to training centers for doctoral programs and traineeships to doctoral or post-doctoral students;
- Grants and Contracts ($12 million) -- comprehensive program to benefit academic and clinical research initiatives;
- Allied Health Research ($20 million) -- support for innovative research projects, including projects to develop the basis for practice in allied health professions;
- Commission on Allied Health ($1.5 million);

- Allied health data system ($5 million) -- create a comprehensive and uniform national database to monitor trends in allied health manpower and education and to make projections on allied health requirements in the future;
- Division of Allied Health within the Bureau of Health Professions (5 full-time equivalent personnel) -- in conjunction with the Commission on Allied Health, to represent the allied health professions and advise Federal agencies and congressional committees.

The Society of Nuclear Medicine Technologist Section believe that the manpower shortage is the greatest issue currently facing nuclear medicine technology. We urge your support for a comprehensive federal initiative. We believe there should be equity in the Federal government's support for the training of all health care professionals: allied health practitioners as well as physicians. An immediate response to this problem must be forthcoming to remedy the current manpower dilemma and deter a potentially more serious manpower shortage in the future.

Written Testimony

Honorable Congressman Henry Waxman
Chair - Subcommittee on Health and the Environment

J. F. Winterstein, D.C.
President
The National College of Chiropractic
Lombard, Illinois

Mr. Chairman, I am grateful for the opportunity to contribute my perspective on the Student Loan Reauthorization process, particularly as it relates to the chiropractic profession. For me and for those whom I represent, specifically the students of The National College of Chiropractic, this is of great significance.

First, allow me to clearly state that I support reauthorization of the educational loan programs that currently exist. Furthermore, I believe that it would be totally inappropriate for Congress to pursue the recommendation of the administration regarding exclusion of Podiatry and Chiropractic students from the HEAL program for reasons which are ostensibly based upon the excessive default rates of the graduates of these professions. While I do not wish to excuse the defaults of chiropractic students, I am confident that the full picture on defaults is not known at this time because there is little experience upon which to judge the potential defaults that will ensue from graduates of allopathic colleges. In short, I urge you not to judge any particular profession too harshly before all of the facts are in evidence. Frankly, it seems the Chiropractic profession has too often been given "short shrift," and I hope it does not happen once again.

I cannot, of course, speak for graduates of podiatric medicine; however, I am well aware of the major efforts that have been made through the Association of Chiropractic Colleges, working in league with Mr. Michael Henningberg toward the reduction of defaults in the chiropractic profession. I do not know to what extent other professional colleges or to what extent proprietary schools have worked to address the default rates in their respective loan programs, but this has been an effort by the Association of Chiropractic Colleges for several years.

I fully recognize the significance of any defaults within government programs, be they student loans or federally insured savings and loan institutions, and I for one want to participate in the solution for such problems. It is to this end that I have attached a copy of the HEAL Default Reduction Policy of The National College of Chiropractic. We believe that there are contributions that can be made by the institutions, and we are committed to making those contributions.

With your indulgence, I would make a few other suggestions:

1. Chiropractic physicians should be given the opportunity to perform public service in exchange for federal loan forgiveness.

2. Chiropractic students should be included in the Health Professions Subsidized Loan (HPSL) program, a program from which they have been excluded from the beginning while all other health profession's students have been included. It seems to me that there would be little to loose by making this change inasmuch as only those institutions with a default rate of 5% or less are permitted to participate in HPSL, in any case.

3. The HEAL repayment schedule is not equitable for graduates of chiropractic colleges inasmuch as the repayment begins on the day they graduate with no opportunity for obtaining licensure, a process that often consumes a full year. This should be rectified by extension of the grace period and by requiring repayment to begin within one year from graduation.

4. There is evidence that some of the large guarantors of HEAL loans actually, in a way, encourage default because in so doing, they can turn the loan over for government collection. Some of our graduates have actually been told that this happens. The result is a lack of re-enforcement by the lending agency and the guarantor of the significance of personal responsibility in the repayment of these loans.

5. I believe it would be appropriate for you to consider increasing the SLS program to provide students with $10,000 per year rather than the $4,000 that is currently allowed.

6. Reform, I believe, is necessary and certainly valuable not only to the Federal government but also to the student who must learn the necessity of personal responsibility for debt. As a college president, I am willing to participate in these needed reforms but, at the same time, I would ask that acceptable default rates be "phased in" so that our students, our colleges, and our profession will not be ravaged by abrupt discontinuation of the relevant loan sources such as HEAL.

Mr. Chairman, I thank you again, and I assure you that if there is any other way that I can be of assistance, I will make every effort to do so.

Respectfully submitted,

James Winterstein, DC

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ISBN 0-16-035404-8
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